

50-10001

BALTIMORE CITY HEALTH DEPARTMENT

50-10001

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Mary Ellen Roscoe

2. DATE
OF
DEATH

Nov. 19, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence
before admission)

A. STATE

B. COUNTY

Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or
HOSPITAL OR location)
INSTITUTION

1710 Madison Ave.

C. CITY OR TOWN

(If outside corporate limits, write RURAL, and give
township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1710 Madison Ave.

c. Length of stay in Baltimore

20 Yrs.

Yrs.
Mos.
Days

5. SEX

Female

6. COLOR OR RACE

Colored

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

Mar. 25, 1900

9. AGE (In years
last birthday)

50Yrs.

If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Domestic

10B. KIND OF BUSINESS OR
INDUSTRY

Resturant

11. BIRTHPLACE (State or foreign country)

Union, W. Va.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Samuel Simpson

14. MOTHER'S MAIDEN NAME

Elizabeth Manns

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

218-22-0486 Miss Bessie Hansbury-2200 McCulloh

17. INFORMANT

ADDRESS

18. 490 X I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A)
DUE TO

Lobar Pneumonia

3 Weeks

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B)
DUE TO

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., In or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov 1, 1950 to Nov 19, 1950, that I last saw the
deceased alive on Nov 19, 1950, and that death occurred at 1 A. m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

Burial

Nov. 23, -50

Arbutus Cem

Baltimore Co. Md.

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

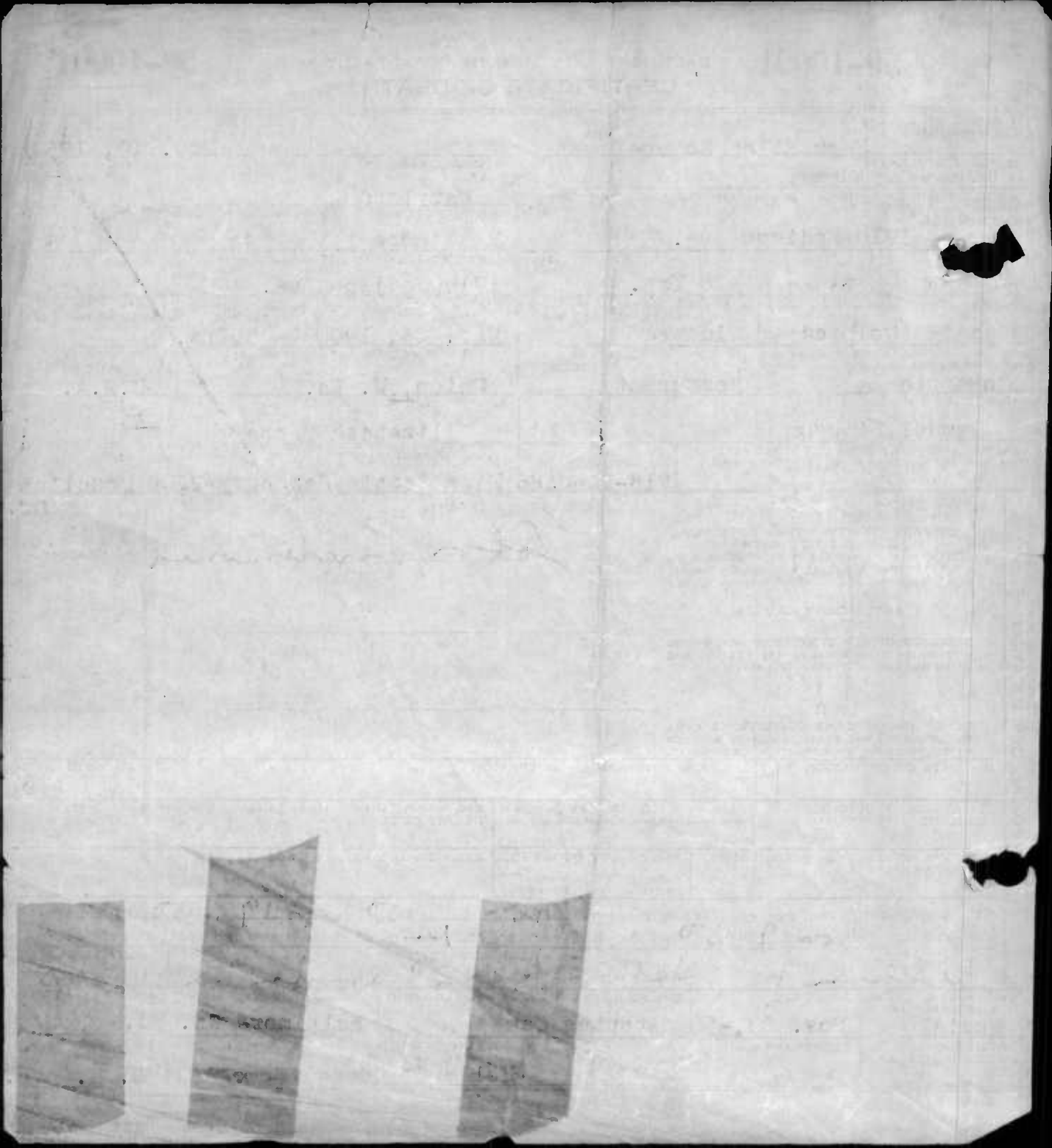
25. FUNERAL DIRECTOR

ADDRESS

NOV 22 1950

Huntington Williams, M.D.

Holland Funeral Home-1631 D. H. Ave.



50-10002

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50-10002
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) MATTIE GEE		2. DATE OF DEATH II-19-50.	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY	
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION 1138 N. Calhoun Street		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore I7., 16-02	
c. Length of stay in Baltimore 15 years Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) 1138 N. Calhoun Street	
5. SEX Female	6. COLOR OR RACE Colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 3-29-1911
9. AGE (In years, last birthday) 39		10. UNDER 1 Year Months Days 7 22	11. UNDER 24 Hours Hours Min. 7 22
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10B. KIND OF BUSINESS OR INDUSTRY at home	
11. BIRTHPLACE (State or foreign country) Charolette, Va.,		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John A. Crawley		14. MOTHER'S MAIDEN NAME Martha Flippers	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. ---	
17. INFORMANT Saml. Gee, 1138 N. Calhoun St.		ADDRESS	

18. 442.X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Carotid Renal Disease DUE TO	CAUSE OF DEATH Carotid Renal Disease (A) normal pregnancy delivery DUE TO (B) secondary anemia DUE TO (C) secondary anemia	INTERVAL BETWEEN ONSET AND DEATH 2 mos. 1 mos 1 mos
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION 0		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 9-10 , 19 50 , to 11-19 , 19 50 , that I last saw the deceased alive on 11-19 , 19 50 , and that death occurred at 12:30 , from the causes and on the date stated above.					
23A. SIGNATURE Franklin Phillips		23B. ADDRESS 1543 Pennsylvania Ave.,		23C. DATE SIGNED 11/22/50	
24A. BURIAL, CREMATION, REMOVAL (Specify) Shipped		24B. DATE II-22-50		24C. NAME OF CEMETERY OR CREMATORY Charolette, Va.,	
24D. LOCATION (City, town, or county) (State) Charolette Co. Va.,		25. FUNERAL DIRECTOR Wm. A. JACKSON-916 PENNA. AVE		ADDRESS	
DATE RECEIVED BY LOCAL REGISTRAR NOV 22 1950		REGISTRAR'S SIGNATURE Wm. A. JACKSON		25. FUNERAL DIRECTOR Wm. A. JACKSON-916 PENNA. AVE	

460 50-19003

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50-19003
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

GRACE TILLERY

2. DATE
OF
DEATH

11/20/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

B. COUNTY

before admission)

MARYLAND

B. FULL NAME OF (If not in hospital or institution, give street address or
HOSPITAL OR location)
INSTITUTION

MERCY HOSPITAL

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

BALTIMORE

14-02

D. STREET ADDRESS (If rural, give location)

1413 MADISON AVE

C. Length of stay in Baltimore

40 Yrs.
Mos.
Days

5. SEX

F

6. COLOR OR RACE

C

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

DIV

8. DATE OF BIRTH

14 FEB 1910

9. AGE (In years

last birthday)

40

If Under 1 Year

Months: Days

If Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

HOUSE WIFE

10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

LUIS TILLERY

14. MOTHER'S MAIDEN NAME

KATHRYN A. SAUNDERS

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown)

NO

(If yes, give war or dates of service)

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

HOSPITAL RECORDS

18. 445X

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A)

Renal failure

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

Malignant hypertension

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e.g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT ☐ NOT WHILE ☐
WORK AT WORK22. I hereby certify that I attended the deceased from 25 Oct, 1950, to 20 Nov, 1950, that I last saw the
deceased alive on 20 Nov, 1950, and that death occurred at 11:30 p.m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

M. D.

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

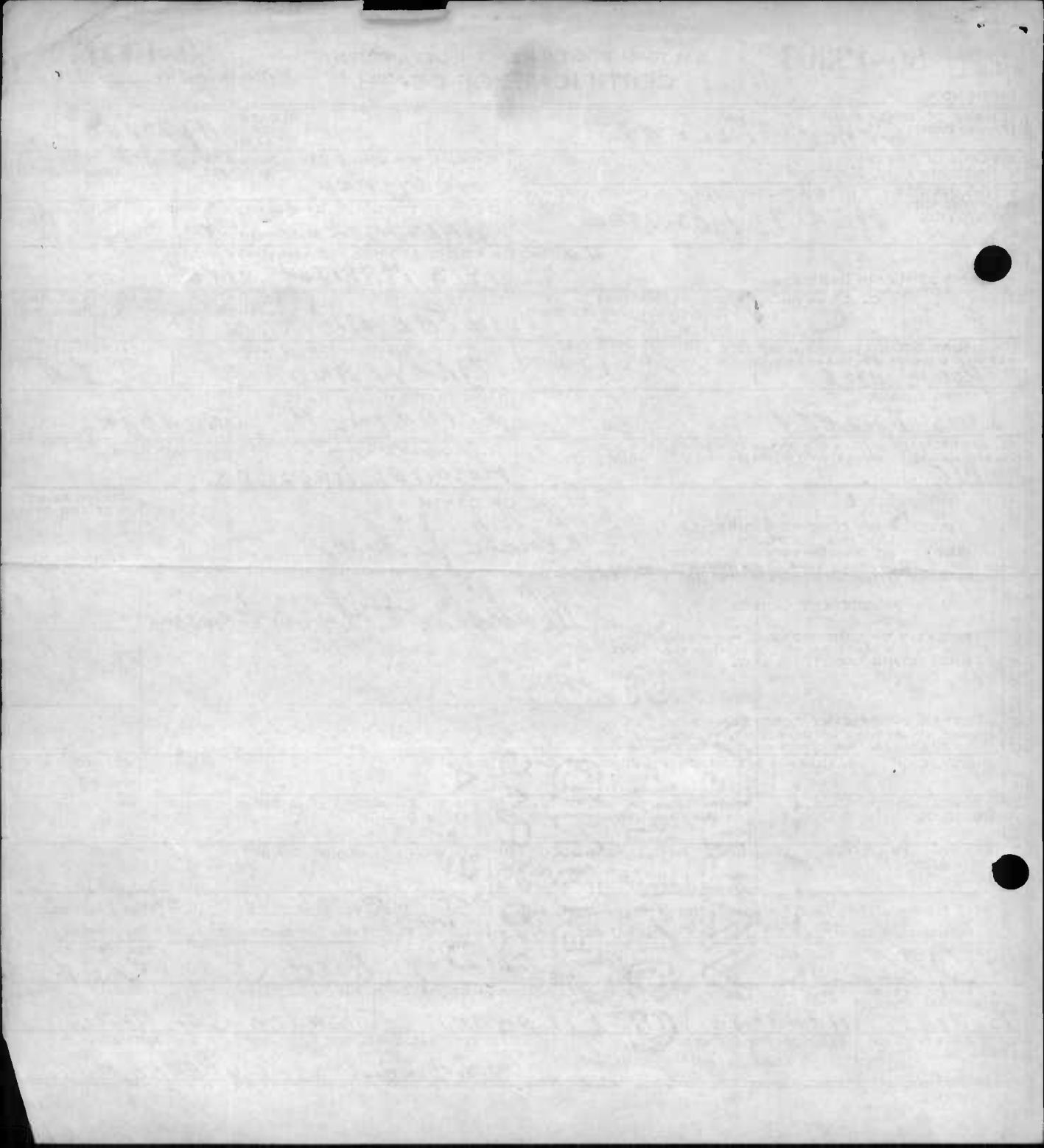
NOV 22 1950

VS 150

WANDA JACKSON - 916 PENNA. AVE.

102.0

MEDICAL CERTIFICATION



165

50-19004

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50-19004
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

ELIZABETH COBURN

2. DATE
OF
DEATH

NOV 21-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

OSL 3

B. FULL NAME OF
HOSPITAL OR
INSTITUTION

JOHNS HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

B. COUNTY

before admission)

MARYLAND

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

BALTIMORE

15-06

D. STREET ADDRESS (If rural, give location)

1801 BRADISH AVE. BRADISH

C. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

FEMALE

6. COLOR OR RACE

WHITE

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

WIDOWED

8. DATE OF BIRTH

5-9-78

9. AGE (In years

last birthday)

72

10. Under 1 Year

Months: Days

11. Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

At Home

10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Ireland

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

John Tague

14. MOTHER'S MAIDEN NAME

Mary

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL
SECURITY NO.

17. INFORMANT

JOHNS HOPKINS HOSPITAL

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A)

Cerebral thrombosis

3 days

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

cerebral arteriosclerosis

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

arteriosclerotic heart disease

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11-17 1950, to 11-21, 1950, that I last saw the
deceased alive on 11-21, 1950, and that death occurred at 1:45 a.m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

JOHNS HOPKINS HOSPITAL

23C. DATE SIGNED

11-21-50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

NOV 22 1950

William M. Williams, M.D.

Howard Strong

3207 W. North Ave

VS 150

093d

MEDICAL CERTIFICATION

10001-10001

10001-10001

2000

General

General

General

11-15-11

General

50-10005

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10005

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Roy W. Speak

2. DATE
OF
DEATH

11-21-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF
HOSPITAL OR
INSTITUTION

(If not in hospital or institution, give street address or location)

University Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

B. COUNTY

before admission)

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

C. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years
last birthday)If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A)

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT ☐
WORKNOT WHILE ☐
AT WORK22. I hereby certify that I attended the deceased from 11-17, 1950 to 11-21, 1950 that I last saw the
deceased alive on 11-21, 1950, and that death occurred at 12:00 P.m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

NOV 22 1950

VS 150

10010

047C

MEDICAL CERTIFICATION

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

516 50-19006

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50-19006

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Eufrasina Luisa Lombardi

2. DATE
OF
DEATH

Nov. 20 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland 1266 Battery Ave

4. USUAL RESIDENCE (Where deceased lived. If institution: residence
A. STATE B. COUNTY before admission)

Md.

B. FULL NAME OF (If not in hospital or institution, give street address or
HOSPITAL OR location)
INSTITUTIONC. CITY OR TOWN (If outside corporate limits, write RURAL and give
Baltimore 24-03 township)

c. Length of stay in Baltimore

33 Yrs.

Yrs.
Mos.
Days

D. STREET ADDRESS (If rural, give location)

1266 Battery Ave

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

July 20 1878

9. AGE (In years-
last birthday)

72

If Under 1 Year
Months: Days

4

If Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR
INDUSTRY

Home

11. BIRTHPLACE (State or foreign country)

Italy
Castiglione Di Carovilli12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Liborio Di Giacomo

14. MOTHER'S MAIDEN NAME

?

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Carlo Lombardi 1266 Battery Ave

18. 470.1 and 002 X

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A)

DUE TO

Coronary artery occlusion

1 day

ANTECEDENT CAUSES

(B)

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

II

(C)

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

Pulmonary tuberculosis

2 yrs.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e.g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April, 1950, to Nov 20, 1950, that I last saw the
deceased alive on Nov 20, 1950, and that death occurred at 2 P.m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

J. McCalline

M. D.

332 1 Frederick Ave

11/21/50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

Burial

Nov. 23 1950 Holy Redeemer

4430 Belair Rd.

Baltimore Md.

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

NOV 22 1950

Washington Williams, Jr.

O. Paul D. Watson 322 S. High

100-100

100-100

100-100

100-100

100-100

100-100

100-100

100-100

100-100

100-100

100-100

100-100

100-100

100-100

100-100

100-100

VALLEY

100-100

300 50-10007

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50-10007

BIRTH NO.

1. NAME OF DECEASED (Type or Print) EUGENE WHITE			2. DATE OF DEATH Nov. 20, 1950		
3. PLACE OF DEATH: A. Baltimore City, Maryland Balto. City			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY		
5. FULL NAME OF HOSPITAL OR INSTITUTION St. Joseph's Hospital			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 9-09		
c. Length of stay in Baltimore 15 Yrs. Yrs. Mos. Days			D. STREET ADDRESS (If rural, give location) 1601 Lamont Ave.		
5. SEX Male	6. COLOR OR RACE Colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH 11/28/1909		9. AGE (In years last birthday) 40
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10B. KIND OF BUSINESS OR INDUSTRY Sparrow Point	11. BIRTHPLACE (State or foreign country) S.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Prince Henry			14. MOTHER'S MAIDEN NAME Pauline English		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS Cephas White 1601 Lamont Ave		

18. E981X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Gunshot wound of abdomen and right chest with peritonitis (A) DUE TO		INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIB. UTING <input type="checkbox"/> CAUSE OF DEATH.		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) Home		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 1601 Lamont Ave.	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY Nov. 6, 1950 6 P. m.		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? Firearms	
22. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input checked="" type="checkbox"/> , undetermined <input type="checkbox"/> .					
23A. SIGNATURE <i>William V. Smith</i>		23B. CHIEF MEDICAL EXAMINER..... <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER..... <input checked="" type="checkbox"/> M.D. MEDICAL INVESTIGATOR..... <input type="checkbox"/>		23C. DATE SIGNED Nov. 21, 1950	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/26/1950		24C. NAME OF CEMETERY OR CREMATORY Bonaventure	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.					

DATE RECEIVED BY LOCAL REGISTRAR NOV 22 1950		REGISTRAR'S SIGNATURE <i>William V. Smith</i>		25. FUNERAL DIRECTOR <i>Oliver S. Wilson</i>	
VS 151		N-869.4		9703U	
				166.0	

MEDICAL CERTIFICATION

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

MARVIN

D.

SULLIVAN

2. DATE
OF
DEATH

November 20, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION

Lutheran Hospital

Yrs.
Mos.
Days

C. Length of stay in Baltimore

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

Aug 17, 1932

9. AGE (In years
last birthday)

18

10. Under 1 Year
Months Days11. Under 24 Hours
Hours Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Auto mechanic

10B. KIND OF BUSINESS OR
INDUSTRY

Penn Bros.

13. FATHER'S NAME

Charles R. Sullivan Sr.

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF
WHAT COUNTRY?

14. MOTHER'S MAIDEN NAME

Mabel L. Le Bon

17. INFORMANT

ADDRESS

Charles R. Sullivan Sr. 2128 Druid Park

18. E812.71

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) Crushing injury of the abdomen

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. EXTERNAL CAUSE WAS
UNDERLYING ☒ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or
about home, farm, factory, street, office bldg., etc.)

Public

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

Reisterstown Road & Oswego Avenue

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY
November 20, 1950 7 p. m.21E. INJURY OCCURRED
WHILE AT ☐ NOT WHILE ☒
WORK AT WORK

21F. HOW DID INJURY OCCUR?

Pedestrian struck by bus 15-13

22. I certify that I took charge of the remains described above, held an Insp. & Inquiry thereon and from
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,
and death in my opinion resulted from: natural causes ☐ accident ☒ suicide ☐ homicide ☐ undetermined ☐.

23A. SIGNATURE

RS Fisher

23B. CHIEF MEDICAL EXAMINER.....☒
ASSISTANT MEDICAL EXAMINER.....☐
MEDICAL INVESTIGATOR.....☐23C. DATE SIGNED
11-21-5024A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

Nov 24/50

24C. NAME OF CEMETERY OR CREMATORY

Lorraine Park

24D. LOCATION (City, town, or county) (State)

Baltimore, Md

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

11-22-50

Paul C. Whineworth 3615-11 Chestnut Ave.

VS 151

N-868.2

55083

170C

MEDICAL CERTIFICATION

10/1/10

UNITED STATES OF AMERICA

10-17-10

STATE OF NEW YORK

10-17-10

10-17-10

10-17-10

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B350450
50-10009

50-10009

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED (Type or Print) <i>Mary Blaine</i>			2. DATE OF DEATH <i>Nov 21st 1950</i>		
3. PLACE OF DEATH: A. Baltimore City, Maryland <i>2123 Sinclair Lane</i>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>Balto</i>		
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>—</i>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Balto 8-02</i>		
c. Length of stay in Baltimore <i>Life</i>			D. STREET ADDRESS (If rural, give location) <i>2123 Sinclair Lane</i>		
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Married</i>	8. DATE OF BIRTH <i>July 26th 1893</i>	9. AGE (In years last birthday) <i>57</i>	10. Under 1 Year Months: Days 11. Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>General Work</i>			10B. KIND OF BUSINESS OR INDUSTRY <i>Boston Stores</i>		
13. FATHER'S NAME <i>Joseph Morrell</i>			14. MOTHER'S MAIDEN NAME <i>Catherine Wachter</i>		
11. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)			12. CITIZEN OF WHAT COUNTRY?		
16. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS <i>Fredrick Goetzke 2123 Sinclair Lane</i>		

18. <i>443X</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	CAUSE OF DEATH (A) <i>Hypertensive Cardio-Vascular Disease</i> DUE TO (B) <i>Aortic Aneurysm (Abdominal)</i> DUE TO (C) <i>Aortic Aneurysm (Abdominal)</i>	INTERVAL BETWEEN ONSET AND DEATH <i>7</i>
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19A. DATE OF OPERATION <i>0</i>	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *Nov 4* 1950 to *Nov 20*, 1950, that I last saw the deceased alive on *Nov 20*, 1950, and that death occurred at *5:15* a.m., from the causes and on the date stated above.

23A. SIGNATURE <i>Thomas J. Brennan</i>	23B. ADDRESS <i>5217 Harford Road</i>	23C. DATE SIGNED <i>11-22-50</i>
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24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>Nov 24 1950</i>	24C. NAME OF CEMETERY OR CREMATORY <i>Balto-beam</i>	24D. LOCATION (City, town, or county) (State) <i>E North Ave Ext. Md.</i>
DATE RECEIVED BY LOCAL REGISTRAR <i>NOV 22 1950</i>		25. FUNERAL DIRECTOR ADDRESS <i>Leo S. Leach 1701-03 N. Patterson Park Ave</i>	

Mr Brennan 5217 Harford Road.

W-426

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50-10010

BIRTH No. 50-10010

1. NAME OF DECEASED (Type or Print) <i>Gertrude Walker</i>			2. DATE OF DEATH <i>11.21.1950</i>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY		
5. FULL NAME OF (If not in hospital or institution, give street address or location) <i>2181 East Bay View</i> HOSPITAL OR INSTITUTE <i>Bay-Wil-Be Convalescent Home</i>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore</i> <i>16-04</i>		
c. Length of stay in Baltimore Yrs. Mos. Days			D. STREET ADDRESS (If rural, give location) <i>1824 Rayner Ave</i>		
5. SEX <i>female</i>	6. COLOR OR RACE <i>colored</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>married</i>	8. DATE OF BIRTH <i>June 7, 1912</i>	9. AGE (In years last birthday) <i>38</i>	10. Under 1 Year Months Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Domestic Service Private Home</i>		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>Baltimore, Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>P</i>			14. MOTHER'S MAIDEN NAME <i>P</i>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS <i>Deceased</i>		

18. <i>026X</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Central Nervous System Lesions</i> (A) <i>Paresis</i> DUE TO	CAUSE OF DEATH <i>Central Nervous System Lesions</i> (A) <i>Paresis</i> DUE TO	INTERVAL BETWEEN ONSET AND DEATH <i>?</i>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <i>Loss of ability to walk</i> (B) <i>Loss of ability to walk</i> DUE TO		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Loss of ability to walk</i> (C) <i>Loss of ability to walk</i>		<i>3 weeks</i>

19A. DATE OF OPERATION <i>0</i>	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *12.1.*, 19*49* to *11.21.*, 19*50*, that I last saw the deceased alive on *11.9.*, 19*50*, and that death occurred at *10 A. m.*, from the causes and on the date stated above.

23A. SIGNATURE <i>James M. Fair</i>	23B. ADDRESS <i>400 N. Carrollton Ave</i>	23C. DATE SIGNED <i>11.21.50</i>
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>11-24-1950</i>	24C. NAME OF CEMETERY OR CREMATORY <i>Mt. Zion Cem.</i>
24D. LOCATION (City, town, or county) (State) <i>Lansdowne Md.</i>	24E. FUNERAL DIRECTOR <i>Wm. H. R. Williams</i>	24F. ADDRESS <i>Schroeder St</i>
DATE RECEIVED BY LOCAL REGISTRAR <i>NOV 22 1950</i>	REGISTRAR'S SIGNATURE <i>Wm. H. R. Williams</i>	

7208A

30c

MEDICAL CERTIFICATION

000000

CERTIFICATE OF DEATH

000000



R-251

50-10011

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10011

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

MRS. ANNA ROSENBERG

2. DATE
OF
DEATH

Nov. 23, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF
HOSPITAL OR
INSTITUTION (If not in hospital or institution, give street address or location)

UNION MEMORIAL HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE
MARYLAND

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

BALTIMORE

D. STREET ADDRESS (If rural, give location)

2502 LINDEN AVE.

c. Length of stay in Baltimore

55

5. SEX

F

6. COLOR OR RACE

W

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

M

8. DATE OF BIRTH

April 7, 1883

9. AGE (In years
last birthday)

67

If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

HOUSEWIFE

10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

RUSSIA

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

NORRIS WEINBERG

14. MOTHER'S MAIDEN NAME

SINA RAE WEINBERG

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS 2502

Patient Anna Rosenberg Linden Ave

18. 581.0

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) cirrhosis of the liver

DUE TO

INTERVAL BETWEEN
ONSET AND DEATH

6 months

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

Oct 19, 1950

19B. MAJOR FINDINGS OF OPERATION

cirrhosis of the liver

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct. 7, 1950, to Nov. 23, 1950, that I last saw the
deceased alive on Nov. 23, 1950, and that death occurred at 2:40 A.M., from the causes and on the date stated above.

23A. SIGNATURE

Alfred S. Nelson

23B. ADDRESS

M. D.

Union Memorial Hospital
Baltimore, Maryland

23C. DATE SIGNED

Nov 23, 1950

24A. BURIAL CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

Nov 23/50

24C. NAME OF CEMETERY OR CREMATORY

Baltimore Helix Cemetery

24D. LOCATION (City, town, or county)

Balto Md

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS 1126

Sol. Peterson & Son W North Ave

NOV 23 1950

VS 150

124 B

MEDICAL CERTIFICATION

100-1001

100-1001

[Faint, illegible text, likely bleed-through from the reverse side of the page]

M-460
50-10012BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50-10012
Registered No.

BIRTH NO.	
1. NAME OF DECEASED (Type or Print) IDA E. MILLER	
2. DATE OF DEATH November 21, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland	
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY	
5. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2817 Parkwood Avenue	
6. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore	
7. STREET ADDRESS (If rural, give location) 2817 Parkwood Avenue	
8. LENGTH OF STAY IN BALTIMORE life	
9. SEX Female	
10. COLOR OR RACE White	
11. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	
12. DATE OF BIRTH May 30, 1907	
13. AGE (In years last birthday) 43	
14. UNDER 1 Year Months: Days: Hours: Min.	
15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife	
16. KIND OF BUSINESS OR INDUSTRY own home	
17. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
18. CITIZEN OF WHAT COUNTRY? USA.	
19. FATHER'S NAME Jacob Kalvansky	
20. MOTHER'S MAIDEN NAME Ada Kalvansky	
21. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
22. SOCIAL SECURITY NO.	
23. INFORMANT ADDRESS Joseph Miller- 2817 Parkwood Avenue	

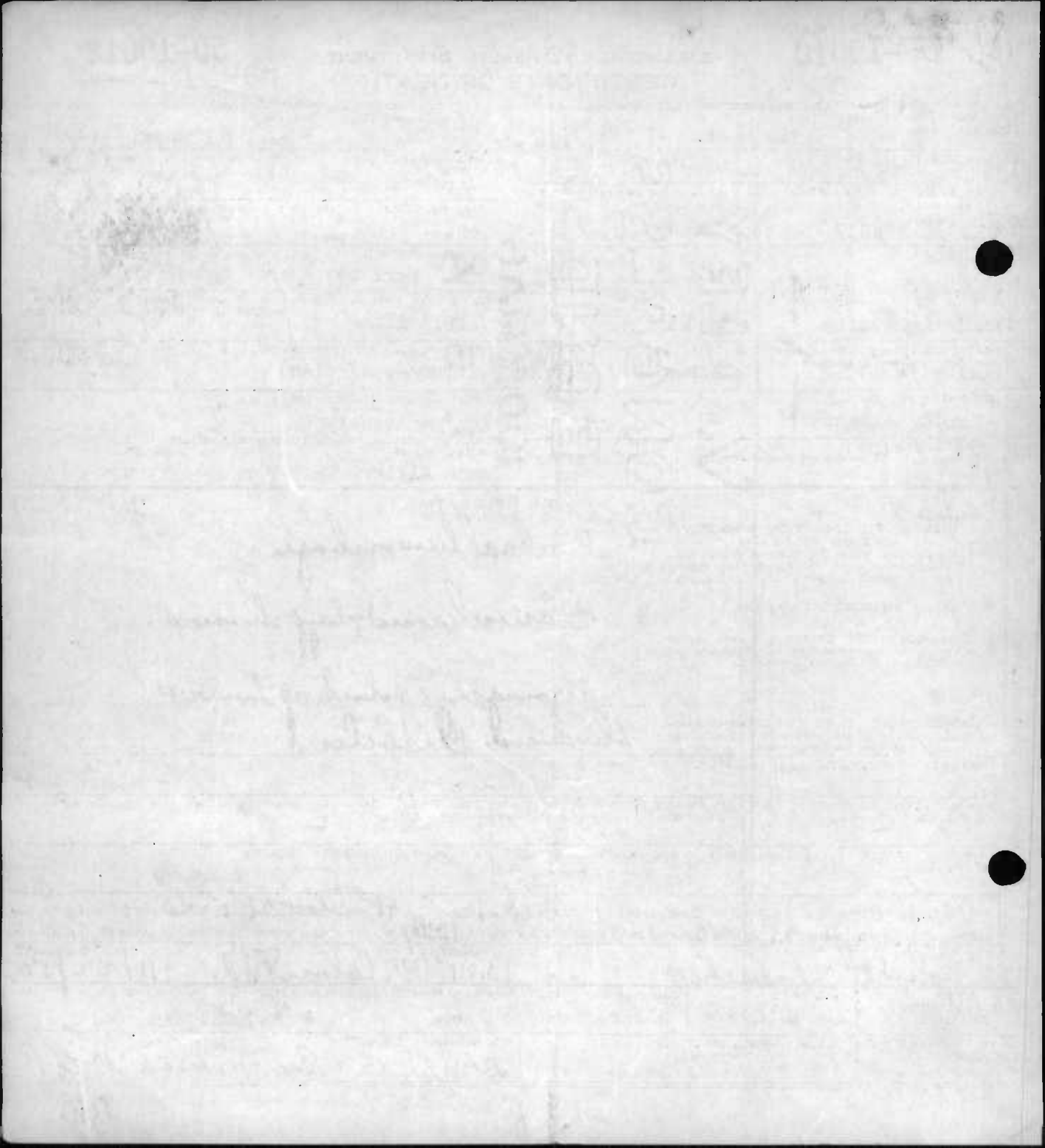
15. 224 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)	
CAUSE OF DEATH (A) Cerebral hemorrhage DUE TO (B) Arteriosclerosis + hypertension. DUE TO (C) Acromegaly + pituitary tumor + blindness. Diabetes.	
INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	

19A. DATE OF OPERATION	
19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from Feb. 14, 1947, to Nov 21, 1950, that I last saw the deceased alive on Nov 21, 1950, and that death occurred at 10:45 p.m., from the causes and on the date stated above.

23A. SIGNATURE John H. Truesher	23B. ADDRESS 1034 W. Calver St.	23C. DATE SIGNED 11/22/50
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24A. BURIAL, CREMATION, REMOVAL (Specify) Burial	24B. DATE 11/23/50	24C. NAME OF CEMETERY OR CREMATORY Mickro- Kodesh Cong.	24D. LOCATION (City, town, or county) (State) Baltimore, Maryland
DATE RECEIVED BY LOCAL REGISTRAR NOV 23 1950	REGISTRAR'S SIGNATURE Huntington Williams, M.D.	25. FUNERAL DIRECTOR Sal. Limson + Bros. - 1124 26 W. North Ave.	ADDRESS



BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50-19013
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

HARRY YOSPY (Jospy)

2. DATE OF DEATH
November 23, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION
(If not in hospital or institution, give street address or location)

2476 Shirley Avenue

52

Yrs.
Mos.
Days

C. Length of stay in Baltimore

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3615 Park Heights Ave.

5. SEX

male

6. COLOR OR RACE

white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

WIDOWER

8. DATE OF BIRTH

1878

9. AGE (In years last birthday)

72

If Under 1 Year
Months DaysIf Under 24 Hours
Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

18-1108

10B. KIND OF BUSINESS OR INDUSTRY

Proprietor

INDUSTRY

11. BIRTHPLACE (State or foreign country)

Russia

12. CITIZEN OF WHAT COUNTRY?

USA.

13. FATHER'S NAME

? Yospy

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS
Emmanuel Yospy 3414 Dolfield Ave.

18.

181X
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

CAUSE OF DEATH

Carcinoma of bladder

Pneumonia

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

M.

WHILE AT WORK ☐NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1948 to Nov, 1950, that I last saw the deceased alive on Nov 22, 1950, and that death occurred at 1, 25 a. m., from the causes and on the date stated above.

23A. SIGNATURE

Mons. G. Fine

M. D.

23B. ADDRESS

115 Arisquik St

23C. DATE SIGNED

11-23-50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

11/23/50

24C. NAME OF CEMETERY OR CREMATORY

Mishkin Israel Cong.

24D. LOCATION (City, town, or county)

Baltimore, Maryland

(State)

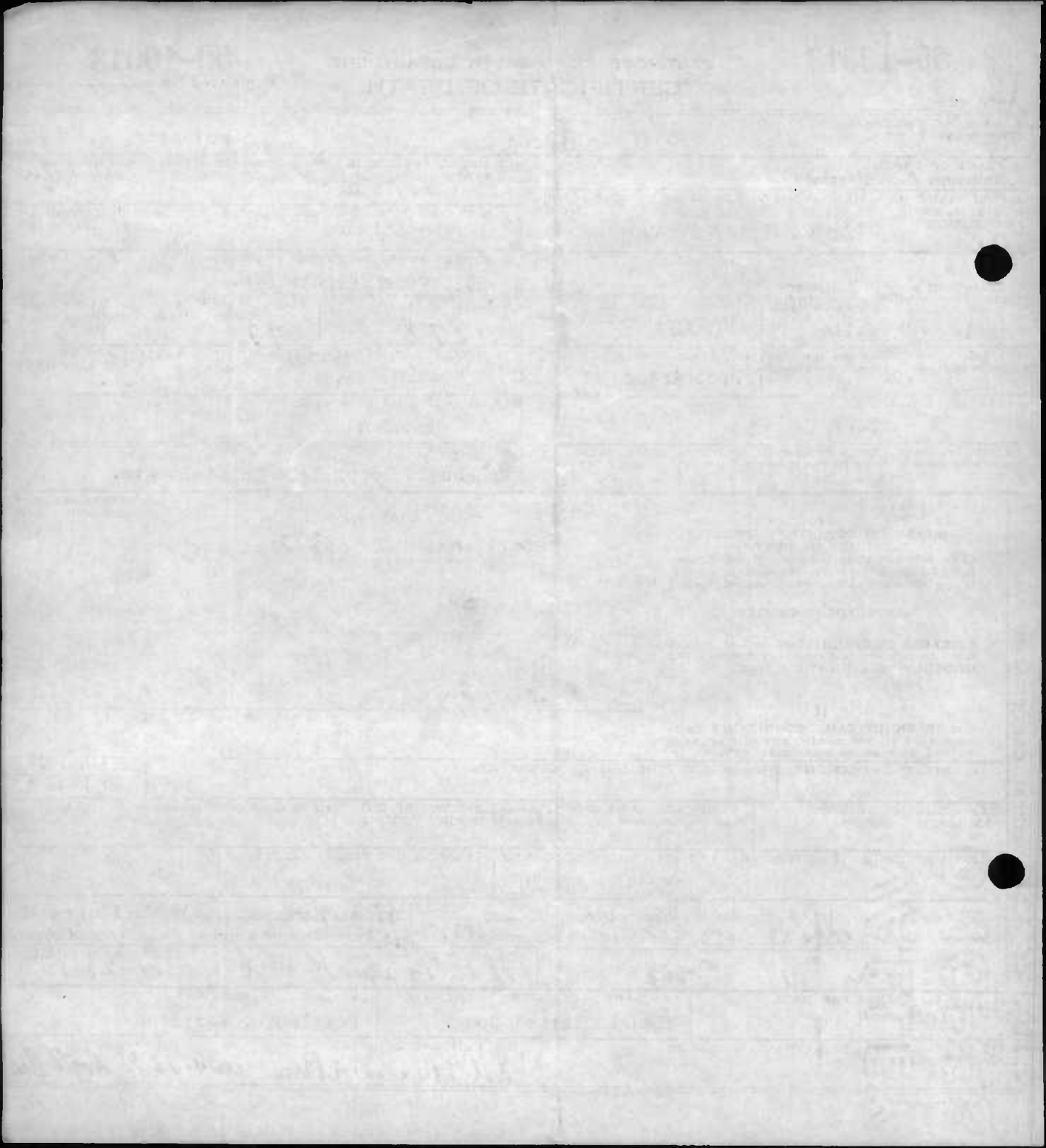
DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

Sol. Levinson & Bros. - 1124-26 W. North Ave.



(5)

50-10014

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50-10014
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Ruth T. Cross

2. DATE
OF
DEATH

21 Nov '50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

B. COUNTY

before admission)

5. FULL NAME OF (If not in hospital or institution, give street address or
HOSPITAL OR location)
INSTITUTION

Mercy Hospital

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1512 N. Elwood Ave. E/wood

c. Length of stay in Baltimore

life

Yrs.
Mos.
Days

5. SEX

f

6. COLOR OF RACE

wh

7. SINGLE, MARRIED

WIDOWED, DIVORCED (Specify)

married

8. DATE OF BIRTH

11 July 1911

9. AGE (In years

last birthday)

39

If Under 1 Year

Months: Days

If Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

housewife

10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Md

12. CITIZEN OF

WHAT COUNTRY?

USA

13. FATHER'S NAME

John M. Murray

14. MOTHER'S MAIDEN NAME

Ethel Childs

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL
SECURITY NO.

220-03-5221

17. INFORMANT

ADDRESS

Mrs. Ethel Murray, 2114 N. Calvert St.

18. 175X1

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) Pelvic carcinoma

15 months

ANTECEDENT CAUSES

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

(over)

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

6 Nov. 1950

19B. MAJOR FINDINGS OF OPERATION

Diffuse pelvic carcinoma

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)

no

21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)

none

21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 16 Nov, 1950, to 21 Nov, 1950, that I last saw the
deceased alive on 19, 1950, and that death occurred at m., from the causes and on the date stated above.

23A. SIGNATURE

Fowler F. White

M. D.

23B. ADDRESS

Mercy Hosp.

23C. DATE SIGNED

21 Nov 1950

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

Nov. 24/50

24C. NAME OF CEMETERY OR CREMATORY

Baltimore National

24D. LOCATION (City, town, or county)

Baltimore, Md.

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Fowler F. White, M.D.

25. FUNERAL DIRECTOR

ADDRESS

Fowler F. White, 4101 Edmondson

If possible, please state
a more definite anatomical
location of the malignant
tumor.

In part: "Carcinoma of ovary". For detailed cause --

See Document File 50-10014

12/6/50

ES

B-635
50-10015BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50-10015
Registered No.

BIRTH NO.		1. NAME OF DECEASED (Type or Print) MADLINE L. BURTON		2. DATE OF DEATH Nov. 21, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore			
B. FULL NAME OF HOSPITAL OR INSTITUTION St. Agnes Hospital		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Relay, Baltimore County			
C. Length of stay in Baltimore Life		D. STREET ADDRESS (If rural, give location) 5116 Rolling Rd.			
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH 3/5/43	9. AGE (In years last birthday) 7	10. Under 1 Year Months: Days: 11. Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10B. KIND OF BUSINESS OR INDUSTRY School		11. BIRTHPLACE (State or foreign country) Ind.	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME James Burton			
14. MOTHER'S MAIDEN NAME Leolares Bush		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.		17. INFORMANT James Burton, Relay, Ind.			
18. E 812.5		CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) Crushing injury of head			
ANTECEDENT CAUSES		(B)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) Street		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) of Patapsco River bridge	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY Nov. 21, 1950 3:15 p. m.		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? Fell from cab run over by truck	
22. I certify that I took charge of the remains described above, held an Inspection & Inq. thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input checked="" type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .					
23A. SIGNATURE Stanley K. Dunsicker		M.D.		23B. CHIEF MEDICAL EXAMINER..... <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER..... <input checked="" type="checkbox"/> 23C. DATE SIGNED Nov. 22, 1950	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE Nov. 24/50		24C. NAME OF CEMETERY OR CREMATORY Meadowridge	
24D. LOCATION (City, town, or county) (State) Relay, Ind.		25. FUNERAL DIRECTOR Harry A. Wible		ADDRESS 4101 Edmondson Ave.	
DATE RECEIVED BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE [Signature]		25. FUNERAL DIRECTOR ADDRESS	

VS 151 N 852.2

5-1013

STATE OF NEW YORK
CERTIFICATE OF DEATH

5-1013

Name of Deceased		Date of Death	
Sex		Age	
Place of Birth		Usual Residence	
Cause of Death		Manner of Death	
Physician's Signature		Medical Examiner's Signature	
Date of Certificate		Place of Death	
County		City or Town	
State		Zip Code	
Registrar's Signature		Registrar's Office	
Date of Registration		Place of Registration	
County		City or Town	
State		Zip Code	

H-120

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHX 50-10016
Registered No.

50-10016

1. NAME OF DECEASED (Type or Print) <i>Flora E. Hobbs</i>			2. DATE OF DEATH <i>11/24/50</i>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MD.</i> B. COUNTY <i>Howard</i>		
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>Union Hospital</i>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Howard Co.</i>		
c. Length of stay in Baltimore Yrs. Mos. Days			D. STREET ADDRESS (If rural, give location) <i>Ellicott City Rd #1</i>		
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>M</i>	8. DATE OF BIRTH <i>6/4</i>	9. AGE (In years last birth day) <i>64</i>	10. Under 1 Year Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>			11. BIRTHPLACE (State or foreign country) <i>MD.</i>		
10B. KIND OF BUSINESS OR INDUSTRY			12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME <i>James B. Johnson</i>			14. MOTHER'S MAIDEN NAME <i>Mary Weaver</i>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
17. INFORMANT <i>Harold A.</i>			ADDRESS		

18. <i>331X</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE. (A) STATING THE UNDERLYING CONDITION LAST.	CAUSE OF DEATH (A) <i>Dehydration, Anemia</i> DUE TO (B) <i>Cerebral Vascular Accident</i> DUE TO (C) <i>Hypertension & Renal Complication</i> <i>Refusal of Medical Care</i>	INTERVAL BETWEEN ONSET AND DEATH
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION <i>11/23/50</i>	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *11-21-50*, 19__, to *11-22-50*, 19__, that I last saw the deceased alive on *11-22-50*, 19__ and that death occurred at *1:20* m., from the causes and on the date stated above.

23A. SIGNATURE <i>Walter B. Brown</i>	M. D.	23B. ADDRESS <i>1426 Light St.</i>	23C. DATE SIGNED <i>11/24/50</i>
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>11/23/1950</i>	24C. NAME OF CEMETERY OR CREMATORY <i>Mt. Olivet</i>	24D. LOCATION (City, town, or county) (State) <i>Balto. Md.</i>
DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR <i>Flynn & Fleming</i>	ADDRESS <i>1426 Light St.</i>

NOV 23 1950
VS 150

083a

MEDICAL CERTIFICATION

100-100

100-100

100-100

100-100

100-100



M-635

50-10017

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50-10017

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Mary

Frances

Martin

2. DATE

OF
DEATH Nov. 23, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution: residence

A. STATE

Maryland

B. COUNTY

before admission)

B. FULL NAME OF (If not in hospital or institution, give street address or location)

Visiting

1532 N. Patterson Park Ave.

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Cottage City

D. STREET ADDRESS (If rural, give location)

3702 - 43rd AVE. 6600

c. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

MARRIED

8. DATE OF BIRTH

OCT. 10/1871

9. AGE (In years
last birthday)

79

10 Under 1 Year
Months: Days11 Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

HOUSEWIFE

10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

BALTIMORE, MD

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

JOHN MARTIN

14. MOTHER'S MAIDEN NAME

UNKNOWN

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

NO

NONE

16. SOCIAL
SECURITY NO.

NONE

17. INFORMANT

ADDRESS

MRS. NETTIE STEEL - 3702 - 43rd AVE
COTTAGE CITY MD

18. 422.1

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) Arteriosclerotic Cardiovascular Disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C) Rheumatoid arthritis

II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

m. WHILE AT ☐ NOT WHILE
WORK AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an - Insp. & Inc. - thereon and from
Autopsy, Inspection or Inquiry
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,
and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

R.S. Fisher

M.D.

23B. CHIEF MEDICAL EXAMINER.....☒ASSISTANT MEDICAL EXAMINER.....☐MEDICAL INVESTIGATOR.....☐

23C. DATE SIGNED

Nov. 23, 1950

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

11/27/1950

24C. NAME OF CEMETERY OR CREMATORY

FORT LINCOLN Cem.

24D. LOCATION (City, town, or county)

COLMAR MANOR, MD

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Wm. W. Chambers

25. FUNERAL DIRECTOR

ADDRESS

Wm. W. Chambers Co - Riverdale, Md.

E-452

50-10018

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50-10018
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

MRS. JULIA ELLINGHAUS

2. DATE
OF
DEATH

21 Nov. 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence
before admission)

A. STATE

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or
HOSPITAL OR location)
INSTITUTION

4112 Edmondson Ave.

MARYLAND

C. CITY OR TOWN

(If outside corporate limits, write RURAL, and give township)

BALTIMORE

9-08

C. Length of stay in Baltimore

LIFE

Yrs.
Mos.
Days

D. STREET ADDRESS (If rural, give location)

2005 KENNEDY AVE

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years,
last birthday)

10 Under 1 Year

11 Under 24 Hours

FEMALE

WHITE

WIDOW

FEB. 1, 1889

61

Months: Days

Hours: Min.

10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR
INDUSTRY

Domestic

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

George W. Miller

14. MOTHER'S MAIDEN NAME

Orma Schnell

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

None

16. SOCIAL
SECURITY NO.

NONE

17. INFORMANT

ADDRESS

May B. Schwal 2101 Frederick Ave

18.

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

CAUSE OF DEATH

(A)

Carcinomatosis, generalized

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

Carcinoma right breast

DUE TO

(C)

INTERVAL BETWEEN
ONSET AND DEATH

2 yrs??

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e.g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

22. TIME (Month) (Day) (Year) (Hour)
OF INJURY

22E. INJURY OCCURRED

22F. HOW DID INJURY OCCUR?

WHILE AT ☐ NOT WHILE ☐
WORK AT WORK22. I hereby certify that I attended the deceased from 11th Oct. 1950 to 21st Nov. 1950, that I last saw the
deceased alive on 21 Nov. 1950, and that death occurred at 2:55 P.M., from the causes and on the date stated above.

23A. SIGNATURE

Joseph E. Muehl

23B. ADDRESS

5 West 29th St. (18)

23C. DATE SIGNED

21 Nov '50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

Burial

Nov. 24, 1950

BALTIMORE CEMETERY BALTIMORE, MD.

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

NOV 23 1950

William H. Williams

Geo. L. Schwab 2101 Frederick Ave

720FA

050.0

MEDICAL CERTIFICATION

850114

RECEIVED

11-1-60

11-1-60

11-1-60

11-1-60

11-1-60



D-140

50-10019

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10019

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

ETHEL B. DUVALL

2. DATE
OF
DEATH

23 Nov. 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF
HOSPITAL OR
INSTITUTION (If not in hospital or institution, give street address or location)

Union Memorial Hospital

Yrs.
Mos.
Days

C. Length of stay in Baltimore

5. SEX

F

6. COLOR OR RACE

W

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Widowed

10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR
INDUSTRY

NONE

13. FATHER'S NAME

R. Tilghman Brice

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

NONE

4. USUAL RESIDENCE (Where deceased lived. If institution: residence
A. STATE B. COUNTY before admission)

Md.

P.A.Co.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Annapolis 5200

D. STREET ADDRESS (If rural, give location)

PO Box 669-A R.F.D.

8. DATE OF BIRTH

1874 Oct. 76

9. AGE (In years
last birth day)If Under 1 Year
Months Days Hours Min.

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

14. MOTHER'S MAIDEN NAME

Mary Elizabeth Stetchcomb

17. INFORMANT

Patient.

ADDRESS

18. 540.0 and 180 X
DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.CAUSE OF DEATH
massive gastric hemorrhage(A)
DUE TO(B)
DUE TO(C)
DUE TOINTERVAL BETWEEN
ONSET AND DEATH

2 hours

? months

? months

II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.Sarcoma of left kidney, advanced,
with metastasis bulky and to the liver

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH21B. PLACE OF INJURY (e.g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m. WHILE AT NOT WHILE
WORK ☐ AT WORK ☐22. I hereby certify that I attended the deceased from 4 Oct, 1950, to 23 Nov, 1950 that I last saw the
deceased alive on 23 Nov., 1950, and that death occurred at 2:15 P.m., from the causes and on the date stated above.

23A. SIGNATURE

Alfred S. Nelson

M. D.

23B. ADDRESS

Union Memorial Hospital
Baltimore, Md.

23C. DATE SIGNED

Nov 23, 1950

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

11-26-50

24C. NAME OF CEMETERY OR CREMATORY

Cedar Bluff

24D. LOCATION (City, town, or county)

Annapolis, Md.

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

NOV 24 1950

William H. Williams, M.D.

John M. S. & Son - Annapolis, Md.

0522

MEDICAL CERTIFICATION

5-1-1913

5-1-1913

Dear Mr. C. C. Curran

I have just received your letter of the 28th

and am glad to hear from you

and hope you are well

I am writing you now

and hope you will

be able to

write me soon

and let me hear

from you

and hope you

will be able to

write me soon

and let me hear

from you

and hope you

will be able to

write me soon

and let me hear

from you

and hope you

will be able to

B-200

50-10020

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

BIRTH NO. 50-10020

1. NAME OF DECEASED
(Type or Print)

LAURENCE M. BUCK

2. DATE
OF
DEATH

Nov. 23, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION

UNION MEMORIAL HOSPITAL

C. Length of stay in Baltimore

Yrs.
Mos.
Days5. SEX
M6. COLOR OR RACE
W7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)
M

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

MARYLAND

B. COUNTY

BALTIMORE

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

BALDWIN

D. STREET ADDRESS (If rural, give location)

5300

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

MANUFACTURER

10B. KIND OF BUSINESS OR INDUSTRY

Glass

8. DATE OF BIRTH

MAY 2, 1883

9. AGE (In years last birthday)

67

11 Under 1 Year
Months Days

0 21

11 Under 24 Hours
Hours Min.

11. BIRTHPLACE (State or foreign country)

BALTIMORE

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

RICHARD B. BUCK

14. MOTHER'S MAIDEN NAME

LAURA GRAFFLIN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT, DR. WALTER BUCK

PATIENT'S NEPHEW

ADDRESS
BALTIMORE

18. 331X I

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) Intra Cranial Hemorrhage

3 days

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Generalized Arterio Sclerosis with

Hypertension

5+ years

DUE TO

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Broncho-Pneumonia

2 days

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from Nov. 20, 1950, to Nov. 23, 1950, that I last saw the deceased alive on Nov. 23, 1950, and that death occurred at 1:40 p.m., from the causes and on the date stated above.

23A. SIGNATURE

Wallace Z. Buttrick M.D.

23B. ADDRESS

Union Memorial Hospital

23C. DATE SIGNED

23 Nov 1950

24A. BURIAL, CREMATION, REMOVAL (Specify)

cremation

24B. DATE

Nov 21

24C. NAME OF CEMETERY OR CREMATORY

Greenmount

24D. LOCATION (City, town, or county) (State)

North Greenmount Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

for Williams, M.D.

25. FUNERAL DIRECTOR

Wm. H. Skelly Jr. Jarrattville Md

ADDRESS

Jarrattville Md

VS 150

NOV 24 1950

29035

083a

MEDICAL CERTIFICATION

CERTIFICATE OF ADOPTION

12 0 2

Blues

Adopted by the Board of Directors
of the [illegible] Company
on the [illegible] day of [illegible] 19[illegible]

R-532
50-10021BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10021

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

FRANK J. RENTZ

2. DATE
OF
DEATH

November 21, 1950.

3. PLACE OF DEATH:

A. Baltimore City, Maryland 259 S. Robinson St.

B. FULL NAME OF (If not in hospital or institution, give street address or
HOSPITAL OR location)
INSTITUTION

c. Length of stay in Baltimore

Yrs.
Mos.
Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

Md.

B. COUNTY

before admission)

C. CITY OR TOWN

Baltimore

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

259 S. Robinson St.

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

March 20, 1890

9. AGE (In years
last birthday)

60

10 Under 1 Year
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Printer

10B. KIND OF BUSINESS OR
INDUSTRY

U.S. Lithographing Co.

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Joseph Rentz

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES?

(Yes, no or unknown)

Yes

(If yes, give war or dates of service)
Oct. 1908-Oct. 191216. SOCIAL
SECURITY NO.

212-09-9644

17. INFORMANT

ADDRESS

Mary S. Rentz 259 S. Robinson St.

18. 420.1 and 170X
DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

CAUSE OF DEATH

(A)

Coronary artery Disease

DUE TO

(B)

Hypertension

DUE TO

(C)

~~Carcinoma Right Breast~~

Carcinoma Right Breast

INTERVAL BETWEEN
ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐
WORKNOT WHILE ☐
AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb 27, 1947 to Nov. 21, 1950, that I last saw the
deceased alive on Nov. 21, 1950, and that death occurred at 3:15 P.M. from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

Edward A. Flanagan Jr. M. D.

3501 Fair Ave. Balto.

11-23-50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

11-24-50.

24C. NAME OF CEMETERY OR CREMATORY

Holy Redeemer Cemetery

24D. LOCATION (City, town, or county)

4430 Belair Rd. Balto. Md.

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

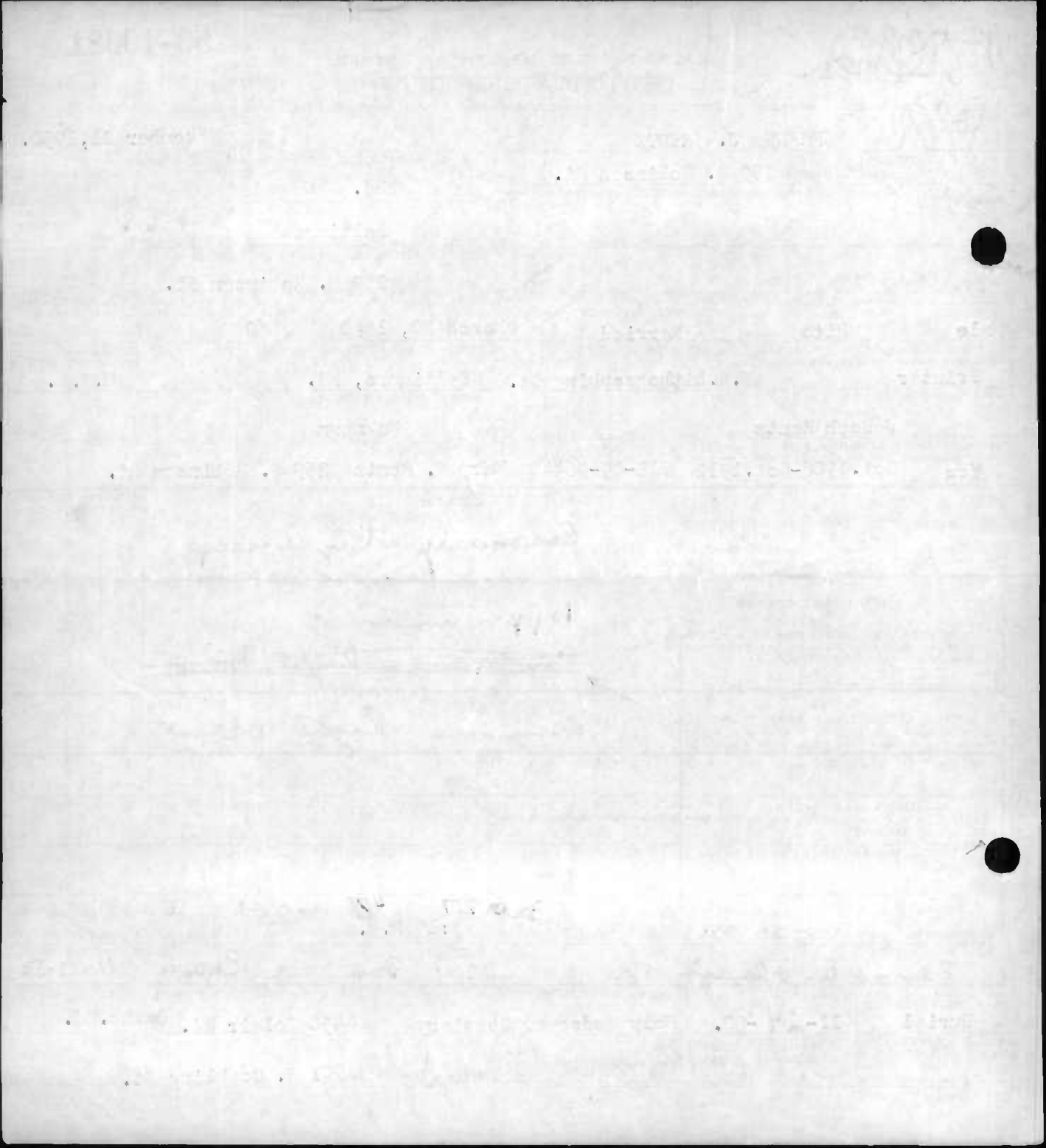
ADDRESS

November 24, 1950

Charles J. Zeiler 901 S. Conkling St.

5124M

050.0



AB-143459

B-160

50-10022

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10022

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Carolyn Beaver

2. DATE
OF
DEATH

11-23-1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence
A. STATE B. COUNTY before admission)

Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or
HOSPITAL OR INSTITUTION location)Baltimore City Hospitals
4940 Eastern Ave.C. CITY OR TOWN (If outside corporate limits, write RURAL and give
Baltimore township)

Baltimore

D. STREET ADDRESS (If rural, give location)

314 S. Patterson Park Ave.,

c. Length of stay in Baltimore

9 months

Yrs.
Mos.
Days

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)
Single

8. DATE OF BIRTH

Oct. 10-1949

9. AGE (in years
last birthday)

1

If Under 1 Year
Months: Days
If Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Pennsylvania

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Samuel Beaver

14. MOTHER'S MAIDEN NAME

Bessie Zimmerman

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.17. INFORMANT ADDRESS
Records: Baltimore City Hospitals
4940 Eastern Ave.

18. 204.0

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATH

2 mos.

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A) Lymphatic Leukemia

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m.

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐22. I hereby certify that I attended the deceased from 11-17-1950, to 11-23-1950 that I last saw the
deceased alive on 11-23-1950 and that death occurred at 1.10Am, from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

4940 Eastern Ave.

23C. DATE SIGNED

M. D.

Baltimore City Hospitals

11-23-50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

NOV 24 1950

VS 150

074a

SS01-7

SS01-7

A. B. M.

D. B. M.

C. B. M.

B. B. M.

A. B. M.

D. B. M.

C. B. M.

B. B. M.

A. B. M.

D. B. M.

P-624

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHX 50-10023
Registered No.

BIRTH NO. 50-10023

1. NAME OF DECEASED (Type or Print) Sidney Purcell		2. DATE OF DEATH NOV. 23, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland M69 1		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE VIRGINIA B. COUNTY V-43	
B. FULL NAME OF HOSPITAL OR INSTITUTION JOHNS HOPKINS HOSPITAL		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Round Hill	
c. Length of stay in Baltimore 5 weeks		D. STREET ADDRESS (If rural, give location)	
5. SEX MALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED	8. DATE OF BIRTH 4-22-90
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineering		10B. KIND OF BUSINESS OR INDUSTRY coal mine	9. AGE (In years last birthday) 60
11. BIRTHPLACE (State or foreign country) Va.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Valentine Purcell		14. MOTHER'S MAIDEN NAME Mary Bruin	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) war 1-		16. SOCIAL SECURITY NO. 224-01-6811	
17. INFORMANT JOHNS HOPKINS HOSPITAL		ADDRESS	

18. 180 X 1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Carcinoma, lympho glandular metastasis in kidney.	CAUSE OF DEATH (A) Carcinoma, lympho glandular metastasis in kidney. (B) same metastasis primary in kidney. (C)	INTERVAL BETWEEN ONSET AND DEATH ? 5 mos.
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION 0	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **10-24**, 19**50**, to **11-23**, 19**50**, that I last saw the deceased alive on **11-23**, 19**50**, and that death occurred at **6:15** am., from the causes and on the date stated above.

23A. SIGNATURE Robert M. Paine	23B. ADDRESS JOHNS HOPKINS HOSPITAL	23C. DATE SIGNED
---------------------------------------	--	------------------

24A. BURIAL, CREMATION, REMOVAL (Specify) Removal	24B. DATE 11/23/50	24C. NAME OF CEMETERY OR CREMATORY Maplewood	24D. LOCATION (City, town, or county) (State) Lagerwell Va
DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE Thurston H. Williams	25. FUNERAL DIRECTOR Call Mortuary Funeral Home	

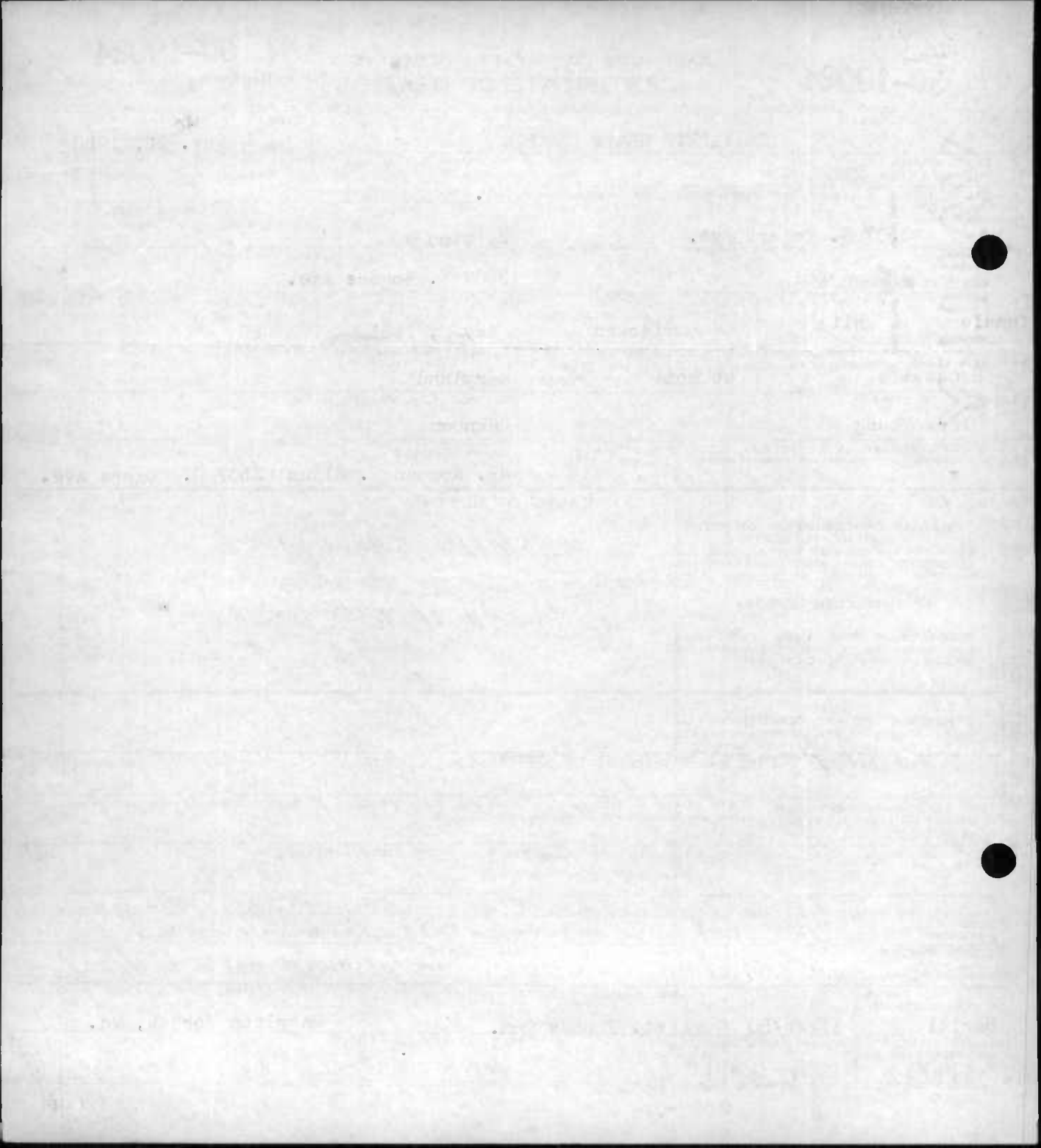
NOV 24 1950

583 21 052a 403-E-25th street
Baltimore - 18. 9nd

MEDICAL CERTIFICATION

G-450
50-10024BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50-10024
Registered No.

1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH	
ELIZABETH GLAUM		Nov. 22, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md.	
B. FULL NAME OF HOSPITAL OR INSTITUTION 3507 W. Rogers Ave.		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore	
c. Length of stay in Baltimore Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) 3507 W. Rogers Ave.	
5. SEX female	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) widowed	8. DATE OF BIRTH May 2, 1881
10A. USUAL OCCUPATION (Give kind of work done during most of worklog life, even if retired) housewife		10B. KIND OF BUSINESS OR INDUSTRY at home	9. AGE (In years last birthday) 69
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Clark Young		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mr. Norman W. Glaum		ADDRESS 3507 W. Rogers Ave.	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) METASTATIC SARCOMA DUE TO (B) SARCOMA OF THE UTERUS DUE TO (C) INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION 0			19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 11/21, 1950, to 11/22, 1950, that I last saw the deceased alive on 11/21, 1950, and that death occurred at 5:10 A.M., from the causes and on the date stated above.			
23A. SIGNATURE Samuel P. Scalis		23B. ADDRESS 1004 REISTERSTOWN ROAD	
23C. DATE SIGNED 11/22/50			
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/25/50	
24C. NAME OF CEMETERY OR CREMATORY St. Thomas Cem.		24D. LOCATION (City, town, or county) (State) Garrison Forest, Md.	
25. FUNERAL DIRECTOR Wm. J. Tiskner & Son - Balto		ADDRESS 0486 md.	



5-354
30-10025BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50-10025
Registered No.

BIRTH NO.			2. DATE OF DEATH		
1. NAME OF DECEASED (Type or Print) ESTHER STANLEY			Nov. 21, 1950		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE VA Maryland B. COUNTY V-43		
B. FULL NAME OF (If not in hospital or institution, give street address or location) University Hospital			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) RICHMOND		
c. Length of stay in Baltimore			D. STREET ADDRESS (If rural, give location) 1339 Lorraine Ave. 4504 Brook Rd		
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) SINGLE	8. DATE OF BIRTH 10-9-1892	9. AGE (In years last birthday) 58	10. Under 1 Year Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PAINTER		10B. KIND OF BUSINESS OR INDUSTRY COMMERCIAL CONST.		11. BIRTHPLACE (State or foreign country) DURHAM N.C.	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME JAMES B. STANLEY		14. MOTHER'S MAIDEN NAME RACHEL GOOCH	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 204-12-2103		17. INFORMANT MR. S. H. UPCHURCH ADDRESS RICHMOND VA.	

18. E812.4 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Subdural hematoma-bilateral (A) DUE TO Antecedent Causes DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Bronchopneumonia Cystitis and bilateral pyonephritis (B) (C) II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	INTERVAL BETWEEN ONSET AND DEATH
---	----------------------------------

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Prince George's Co. Washington Blvd. 100' N. of Bowie Rd.
21D. TIME (Month) (Day) (Year) (Hour) June 16, 1950 7 Pm.	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21F. HOW DID INJURY OCCUR? Pedestrian struck by auto

22. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE Stanley K. Ouelacher M.D.	23B. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> MEDICAL INVESTIGATOR <input type="checkbox"/>	23C. DATE SIGNED Nov. 22, 1950
24A. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24B. DATE 11-24-50	24C. NAME OF CEMETERY OR CREMATORY ST. PETERS CEM
24D. LOCATION (City, town, or county) BALTO. MD		(State)

DATE RECEIVED BY LOCAL REGISTRAR NOV 24 1950	REGISTRAR'S SIGNATURE [Signature]	25. FUNERAL DIRECTOR Wm. J. Jackson - Sons Inc.	ADDRESS Baltimore Md
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VS 151 N-854.1 56424 170C

H-532
50-10026BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50-10026
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

CHARLES H. HEINTZEMAN, Sr.

2. DATE
OF
DEATH

Nov. 21, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland *Baltimore City, Md.*B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR INSTITUTE*South Balto. General Hospital*

C. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

M married

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Own Real Estate (Rtd)

10B. KIND OF BUSINESS OR INDUSTRY

Real Estate

13. FATHER'S NAME

Henry Heintzman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL SECURITY NO.

no

8. DATE OF BIRTH

Dec. 9, 1871

9. AGE (in years last birthday)

*78*11 Under 1 Year
Months: Days11 Under 24 Hours
Hours: Min.

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

14. MOTHER'S MAIDEN NAME

Catherine Link

17. INFORMANT

ADDRESS *Clifton Pk. Lake Cottage**Mr. Charles H. Heintzman, Jr.*

INTERVAL BETWEEN ONSET AND DEATH

18. *420.0*

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) *Congestive Heart Failure*

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) *Arterio-sclerotic Heart Disease*

DUE TO

(C) *Arterio-sclerosis*

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *Nov. 7*, 19*50*, to *Nov 21*, 19*50*, that I last saw the deceased alive on *Nov 21*, 19*50*, and that death occurred at *8:50 p.m.*, from the causes and on the date stated above.

23A. SIGNATURE

D. C. P. Quinn

M. D.

23B. ADDRESS

South Balto. Gen Hospital

23C. DATE SIGNED

11-21-50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

11/24/50

24C. NAME OF CEMETERY OR CREMATORY

Western Cem.

24D. LOCATION (City, town, or county)

Balto., Md.

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

John Williams, M.D.

25. FUNERAL DIRECTOR

Wm. J. Tiekner & Sons - Balto

ADDRESS

~~CONFIDENTIAL~~

CONFIDENTIAL

CONFIDENTIAL

CONFIDENTIAL

CONFIDENTIAL

CONFIDENTIAL

CONFIDENTIAL

CONFIDENTIAL

CONFIDENTIAL

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CONFIDENTIAL

CONFIDENTIAL

CONFIDENTIAL

YY-623
50-10027

CERTIFICATE CORRECTED 3-2-51

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

50-10027

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

SARAH FRANCES WRIGHT

2. DATE
OF
DEATH

Nov. 22, 1950

3. PLACE OF DEATH.

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR INSTITUTION

Madison Apts.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Md.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

817 St. Paul St.

C. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

female

6. COLOR OR RACE

white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

1866
Mar. 22, 1866

9. AGE (In years last birthday)

84 85

If Under 1 Year Months: Days Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

at home

11. BIRTHPLACE (State or foreign country)

-

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

William M. Keech

14. MOTHER'S MAIDEN NAME

Olivia -

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

16. SOCIAL SECURITY NO.

17. INFORMANT

Mr. W. S. Wright - 1718 Abingdon Ave.

ADDRESS
Alexandria, Va

18. 420.1

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

Cerebral Hemorrhage

INTERVAL BETWEEN ONSET AND DEATH

1 hr

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(B)

DUE TO

(C)

myocarditis
hypertension
arterio sclerosis
Coronary artery disease

General
✓
✓
✓

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from Oct 1942 to Nov 22, 1950 that I last saw the deceased alive on Nov 21, 1950 and that death occurred at 8 A m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

11/25/50

24C. NAME OF CEMETERY OR CREMATORY

Druid Ridge Cem.

24D. LOCATION (City, town, or county)

Pikesville, Md.

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

NOV 24 1950

W. S. Wright

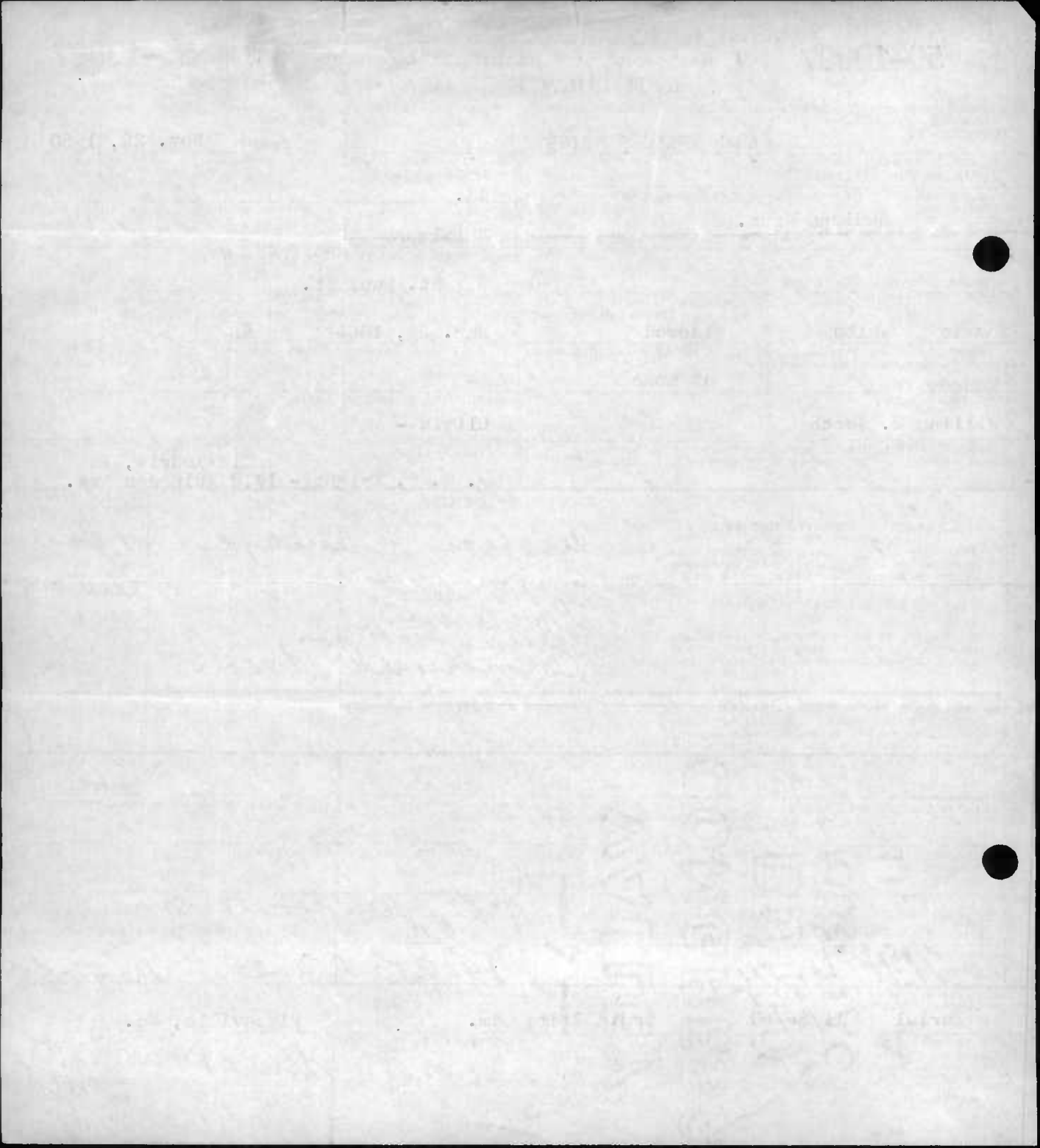
W. S. Wright & Sons, Baltimore, Md.

VS 150

093 d

md

MEDICAL CERTIFICATION



F-435

50-10028

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50-10028
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Feldmeyer, William D.

2. DATE
OF
DEATH

11/22/50 5:30 A.M.

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Md.

Baltimore

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION

Franklin Square Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

c. Length of stay in Baltimore

Life

Yrs.
Mos.
Days

D. STREET ADDRESS (If rural, give location)

1098 Dumbarton Rd.

5300

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED

WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

3/8/1878

9. AGE (In years last birthday)

72

10. Under 1 Year

Months: Days

8 14

11. Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Retired Engineer

10B. KIND OF BUSINESS OR INDUSTRY

PENN. R.R.

13. FATHER'S NAME

William Feldmeyer

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

14. MOTHER'S MAIDEN NAME

Julia A. Myers

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)

Yes

Spanish American War

16. SOCIAL SECURITY NO.

717-08-5889

17. INFORMANT

ADDRESS

The Anna Feldmeyer 109 Dumbarton Rd

18. 420.6

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial Infarction

10 min.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Anteriorly located heart disease

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C) Generalized arteriosclerosis & Anteriorly located heart disease

2 years

19A. DATE OF OPERATION

11/15/50

19B. MAJOR FINDINGS OF OPERATION

Duodenal ulcer

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11/4/50, 1950, to 11/22/50, 1950, that I last saw the deceased alive on 11/21, 1950, and that death occurred at 5:30 A.M., from the causes and on the date stated above.

23A. SIGNATURE

Robert B. Chambers

M.D.

23B. ADDRESS

Franklin Square Hospital

23C. DATE SIGNED

11/22/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

11-25-1950

24C. NAME OF CEMETERY OR CREMATORY

Parkwood Cemetery

24D. LOCATION (City, town, or county)

Baltimore Md

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Tutington Williams, Jr.

25. FUNERAL DIRECTOR

ADDRESS

Ehmer W. Conklin 924 E. Eager St

NOV 24 1950

54150

1176

MEDICAL CERTIFICATION



P-413

50-10029

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50-10029
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

ANNA PELOVITZ

2. DATE
OF
DEATH

Nov 24 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF
HOSPITAL OR
INSTITUTION (If not in hospital or institution, give street address or location)

Swan

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Md

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore 15-12

D. STREET ADDRESS (If rural, give location)

3741 Park Heights Ave

c. Length of stay in Baltimore

47

Yrs.
Mos.
Days

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

9. AGE (In years last birthday)

68

10. Under 1 Year

Months: Days

11. Under 24 Hours

Hours: Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

House Wife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Lith

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Not Known

14. MOTHER'S MAIDEN NAME

Not Known

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Abraham Pelovitz - Same

18. 578 X

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

Gastro-intestinal bleeding, site undetermined.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

Anemia

(C) Pulmonary edema

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from Nov 21, 1950, to Nov 24, 1950, that I last saw the deceased alive on Nov 24, 1950, and that death occurred at 6:34 a.m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

Frank E. Wilton

M. D.

Gruis Hosp. Baltimore

Nov 24

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

Burial

11-24-50

Mt Carmel

Baltimore, Md

DATE RECEIVED BY LOCAL REGISTRAR

Huntington Williams, M.D.

Jack Lewis, 2100 Cutaw Pl

NOV 24 1950

VS 150

12310

MEDICAL CERTIFICATION

50-1083

UNITED STATES DEPARTMENT OF JUSTICE

FEDERAL BUREAU OF INVESTIGATION

50-1083



**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

50-10030

Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED (Type or Print) <u>Sylvia Cohen</u>		2. DATE OF DEATH <u>11-22-50</u>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY _____	
B. FULL NAME OF (If not in hospital or institution, give street address or location) <u>Sinai Hosp</u>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <u>Baltimore 15-10</u>	
c. Length of stay in Baltimore		D. STREET ADDRESS (If rural, give location) <u>4108 Dorchester Road</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY <u>Student</u>	
13. FATHER'S NAME <u>Abraham Cohen</u>		14. MOTHER'S MAIDEN NAME <u>Ida Rudman</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Abraham Cohen - Same</u>		ADDRESS _____	

18. SSIX and E945X
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

Anesthetic Death

INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(A) DUE TO

(B) DUE TO

(C) DUE TO

CERTIFICATION APPROVED BY

R. Fisher

M. D.

CHIEF OR ASST. MEDICAL EXAMINER

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION <u>11/22/50</u>		19B. MAJOR FINDINGS OF OPERATION <u>Proposed Appendectomy</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) <u>Accident</u>	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) <u>Hospital</u>	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>Sinai Hospital-Monument and Rutland Ave.</u>		
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>Nov. 22, 1950 2 P.m.</u>	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21F. HOW DID INJURY OCCUR? <u>Syncope and respiratory failure due to sodium pentothal anesthesia</u>		

22. I hereby certify that I attended the deceased from 11-21, 1950, to 11-22, 1950, that I last saw the deceased alive on 11-22, 1950, and that death occurred at 4:15 P.m., from the causes and on the date stated above.

23A. SIGNATURE <u>Leonard L. Deitz</u>	23B. ADDRESS <u>Sinai Hosp</u>	23C. DATE SIGNED <u>11-22-50</u>
--	--------------------------------	----------------------------------

24A. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>11-26-50</u>	24C. NAME OF CEMETERY OR CREMATORY <u>Rosedale</u>	24D. LOCATION (City, town, or county) (State) <u>Balto Md</u>
DATE RECEIVED BY LOCAL REGISTRAR <u>NOV 24 1950</u>	REGISTRAR'S SIGNATURE <u>Jack Lewis</u>	25. FUNERAL DIRECTOR <u>2100 Canton Rd</u>	

VS 150

Leonard L. Deitz

121

MEDICAL CERTIFICATION

STATE OF TEXAS
CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age		4. Date of death	
5. Place of death		6. Cause of death		7. Manner of death		8. Signature of physician	
9. Signature of registrar		10. Signature of informant		11. Signature of witness		12. Signature of funeral director	
13. Signature of undertaker		14. Signature of cemetery		15. Signature of burial place		16. Signature of burial place	
17. Signature of burial place		18. Signature of burial place		19. Signature of burial place		20. Signature of burial place	
21. Signature of burial place		22. Signature of burial place		23. Signature of burial place		24. Signature of burial place	
25. Signature of burial place		26. Signature of burial place		27. Signature of burial place		28. Signature of burial place	
29. Signature of burial place		30. Signature of burial place		31. Signature of burial place		32. Signature of burial place	
33. Signature of burial place		34. Signature of burial place		35. Signature of burial place		36. Signature of burial place	
37. Signature of burial place		38. Signature of burial place		39. Signature of burial place		40. Signature of burial place	
41. Signature of burial place		42. Signature of burial place		43. Signature of burial place		44. Signature of burial place	
45. Signature of burial place		46. Signature of burial place		47. Signature of burial place		48. Signature of burial place	
49. Signature of burial place		50. Signature of burial place		51. Signature of burial place		52. Signature of burial place	
53. Signature of burial place		54. Signature of burial place		55. Signature of burial place		56. Signature of burial place	
57. Signature of burial place		58. Signature of burial place		59. Signature of burial place		60. Signature of burial place	
61. Signature of burial place		62. Signature of burial place		63. Signature of burial place		64. Signature of burial place	
65. Signature of burial place		66. Signature of burial place		67. Signature of burial place		68. Signature of burial place	
69. Signature of burial place		70. Signature of burial place		71. Signature of burial place		72. Signature of burial place	
73. Signature of burial place		74. Signature of burial place		75. Signature of burial place		76. Signature of burial place	
77. Signature of burial place		78. Signature of burial place		79. Signature of burial place		80. Signature of burial place	
81. Signature of burial place		82. Signature of burial place		83. Signature of burial place		84. Signature of burial place	
85. Signature of burial place		86. Signature of burial place		87. Signature of burial place		88. Signature of burial place	
89. Signature of burial place		90. Signature of burial place		91. Signature of burial place		92. Signature of burial place	
93. Signature of burial place		94. Signature of burial place		95. Signature of burial place		96. Signature of burial place	
97. Signature of burial place		98. Signature of burial place		99. Signature of burial place		100. Signature of burial place	

G-530
50-10031BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

X 50-10031

Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED
(Type or Print)

ANNIE GUMBY GUNDY

2. DATE
OF
DEATH

20 Nov 50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR INSTITUTIONgood Samaritan Hosp
27 N Carey St

C. Length of stay in Baltimore

Yrs.
Mos.
Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

before admission)

Md

Baltimore

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Towson

D. STREET ADDRESS (If rural, give location)

426 E. Penna. Ave 5300

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years
last birthday)If Under 1 Year
Months Days If Under 24 Hours
Hours Min.10A. USUAL OCCUPATION (Give kind of
work during most of working life, even if retired)10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Henry Jackson

14. MOTHER'S MAIDEN NAME

Mary Conter

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Marie Johnson
Marie Johnson - 3356 Washington St

18.

171X

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

CAUSE OF DEATH

(A) Carcinoma of the cervix

DUE TO with metastases

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m. WHILE AT ☐ NOT WHILE ☐
WORK AT WORK22. I hereby certify that I attended the deceased from 6 Nov, 1950, to 20 Nov, 1950, that I last saw the
deceased alive on 20 Nov, 1950, and that death occurred at 11:30 P.m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

Emil H. Hemming, M.D.

601 Winans Way

21 Nov 50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

Burial

11-24-50

Pleasant Rest Cem

Towson

Md.

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

NOV 24 1950

Antonia Williams, M.D.

Mamie W. Wright - 721 Arisquith St

7208A

over

048a

informant - Marie Johnson

3351 Farnington St.

Flushing L. I. N. Y.

B-230
50-10032BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50-10032
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) CHARLES OSBORNE BECKETT			2. DATE OF DEATH November 23, 1950		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY		
B. FULL NAME OF (If not in hospital or institution, give street address or location) 3026 Garrison Blvd.			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore		
c. Length of stay in Baltimore 71 years			D. STREET ADDRESS (If rural, give location) 3026 Garrison Blvd.		
5. SEX male	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) single	8. DATE OF BIRTH 9-18-79	9. AGE (In years last birthday) 71	10. Under 1 Year Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) salesman			10B. KIND OF BUSINESS OR INDUSTRY Linen Thread Co. (M)		
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Charles F. Beckett			14. MOTHER'S MAIDEN NAME Sarah A. McCauley		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, oo or uok oown) (If yes, give war or dates of service) no			16. SOCIAL SECURITY NO. 213-09-4651		
17. INFORMANT Miss Eunice Beckett King			ADDRESS 3026 Garrison Blvd. Balto. 16, Md.		
18. 47721 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease (A) DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO (C) II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE <input type="checkbox"/> AT WORK		21F. HOW DID INJURY OCCUR?	
22. I certify that I took charge of the remains described above, held an <u>Inquiry & Inspection</u> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .					
23A. SIGNATURE R. S. Fisher		23B. CHIEF MEDICAL EXAMINER..... <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER..... <input type="checkbox"/> MEDICAL INVESTIGATOR..... <input type="checkbox"/>		23C. DATE SIGNED Nov. 24, 1950	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE Nov. 26, 1950.		24C. NAME OF CEMETERY OR CREMATORY St. John's Cemetery	
24D. LOCATION (City, town, or county) Ellicott City, Md.		25. FUNERAL DIRECTOR Easton Sons, Ellicott City, Md.		ADDRESS	
DATE RECEIVED BY LOCAL REGISTRAR NOV 24 1950		REGISTRAR'S SIGNATURE Emmington Williams		4904E	

T-340

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50-10033

BIRTH NO. 50-10033 N.R.		1. NAME OF DECEASED (Type or Print) EDWARD TOATLEY		2. DATE OF DEATH November 19, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY			
B. FULL NAME OF HOSPITAL OR INSTITUTION 1115 Tiffany Court		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 11-04			
c. Length of stay in Baltimore		D. STREET ADDRESS (If rural, give location) 1115 Tiffany Court			
5. SEX Male	6. COLOR OR RACE Colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Child	8. DATE OF BIRTH 6/1/50		9. AGE (In years last birthday) 5
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Columbia S.C.	
13. FATHER'S NAME Edward P. Toatley		14. MOTHER'S MAIDEN NAME Elizabeth Washington			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Elizabeth W. Toatley	
				ADDRESS 1116 Tiffany Court	

18. 782X

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Malnutrition
with scurvy

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	

22. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE R. S. Frohe		23B. CHIEF MEDICAL EXAMINER..... M.D. ASSISTANT MEDICAL EXAMINER..... MEDICAL INVESTIGATOR.....		23C. DATE SIGNED 11-20-50	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE Nov 24, 1950		24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn	
24D. LOCATION (City, town, or county) (State) Balto. Md.		24E. DATE RECEIVED BY LOCAL REGISTRAR 24/1950		24F. REGISTRAR'S SIGNATURE Huntington Williams, M.D.	
24G. FUNERAL DIRECTOR Holland Funeral Home		24H. ADDRESS 067.0 1431 W. 14th Hill Ave.			

UNITED STATES DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY

EX-107

OFFICE OF THE CHIEF, BUREAU OF PLANT INDUSTRY

WASHINGTON, D. C.

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J-250
50-10034BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10034

Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED (Type or Print) WILLIAM H. JACKSON			2. DATE OF DEATH November 22, 1950		
3. PLACE OF DEATH: a. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Maryland b. COUNTY _____		
b. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTE Union Memorial Hospital			c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore		
c. Length of stay in Baltimore 9 yrs.			d. STREET ADDRESS (If rural, give location) 1213 Eutaw Place		
5. SEX male	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Apr. 30 1895	9. AGE (In years last birthday) 55	If Under 1 Year Months: Days If Under 24 Hours Hours: Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manager-Parbbs (R) McComas co.			11. BIRTHPLACE (State or foreign country) Paris- Texas		
10b. KIND OF BUSINESS OR INDUSTRY			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Levi W. Jackson			14. MOTHER'S MAIDEN NAME UNK.		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) Yes			16. SOCIAL SECURITY NO. 455-01-3738		
17. INFORMANT Emma S. Jackson-Same			ADDRESS		

18. 4221 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease (A) DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO (C) _____	CAUSE OF DEATH Arteriosclerotic cardiovascular disease	INTERVAL BETWEEN ONSET AND DEATH
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIB. UTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE <input type="checkbox"/> WORK AT WORK	21f. HOW DID INJURY OCCUR?			
22. I certify that I took charge of the remains described above, held an <u>Inquiry & Inspection</u> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .					
23a. SIGNATURE R. J. Fisher		23b. CHIEF MEDICAL EXAMINER..... <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER..... <input type="checkbox"/> MEDICAL INVESTIGATOR..... <input type="checkbox"/>		23c. DATE SIGNED Nov. 22, 1950	

24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE NOV. 24/50	24c. NAME OF CEMETERY OR CREMATORY Balto. National	24d. LOCATION (City, town, or county) (State) BALTIMORE MARYLAND
DATE RECEIVED BY LOCAL REGISTRAR NOV 24 1950	REGISTRAR'S SIGNATURE W. J. Williams	25. PUBLIC HEALTH DIRECTOR F. B. Wippert & Son	ADDRESS 2906 J 0932 F.B. WIPPERT & SON 1300 EUTAW PLACE.

H-625
50-10035BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50-10035

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Mellie Virginia Harrison

2. DATE
OF
DEATH

11/22/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

Bald

B. FULL NAME OF
HOSPITAL OR
INSTITUTION (If not in hospital or institution, give street address or location)

229 N Linwood

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

B. COUNTY

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Bald

D. STREET ADDRESS (If rural, give location)

229 N Linwood

c. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

Aug 22/1873

9. AGE (In years last birthday)

77

If Under 1 Year

Months: Days

If Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

at home

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Bald

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

James T Harrison

14. MOTHER'S MAIDEN NAME

Anna S. Pryor

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Helen M. Clintock 229 N Linwood

18. 420.1

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

CAUSE OF DEATH McClintock

(A)

Coronary Thrombosis

DUE TO Cardiac & vascular Renal

(B)

arterio sclerosis

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

(stat)

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OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office hldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 1, 1950, to Nov 22, 1950, that I last saw the deceased alive on Nov 1, 1950, and that death occurred at 5:30 A. M., from the causes and on the date stated above.

23A. SIGNATURE

Louis F. Harrison

23B. ADDRESS

222 No. Kenwood Ave

23C. DATE SIGNED

11/23/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

Nov 25/50

24C. NAME OF CEMETERY OR CREMATORY

Bald Cam

24D. LOCATION (City, town, or county) (State)

Bald

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, Jr.

25. FUNERAL DIRECTOR

ADDRESS

Wellington Funeral Home 2004 Calver

VS 150

131a

2254

312

[Faint handwritten text]

9/10/2000

S. A.

James H. Brown

Wm. C. C. C. C.

1890

1892-1893

G-650

CERTIFICATE CORRECTED 4-4-52

50-10036

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

50-10036

1. NAME OF DECEASED
(Type or Print)

Forrest Green

2. DATE
OF
DEATH

11/22/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence
A. STATE B. COUNTY before admission)6. FULL NAME OF (If not in hospital or institution, give street address or
HOSPITAL OR location)
INSTITUTION

Maryland General Hospital Baltimore 9-04

c. Length of stay in Baltimore

Yrs.
Mos.
Days

o. STREET ADDRESS (If rural, give location)

2717 Greenmount Ave

5. SEX

Male

6. COLOR OR RACE

white

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

MARRIED

8. DATE OF BIRTH

7-17-98

9. AGE (In years
last birthday)

52

H Under 1 Year
Months: DaysH Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Salesman

10B. KIND OF BUSINESS OR
INDUSTRY

UNKNOWN

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Lozano

S.

14. MOTHER'S MAIDEN NAME

Elyse & Browning

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Russell Faircloth

as above

18. 151X

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A)

Cardiovascular collapse unknown

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

Gastric hemorrhage unknown

DUE TO

(C)

Malignant gastric ulcer unknown

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY21E. INJURY OCCURRED
WHILE AT ☐ NOT WHILE
WORK AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11/22, 1950, to 11/22, 1950, that I last saw the
deceased alive on 11/22, 1950, and that death occurred at 9:55 pm., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

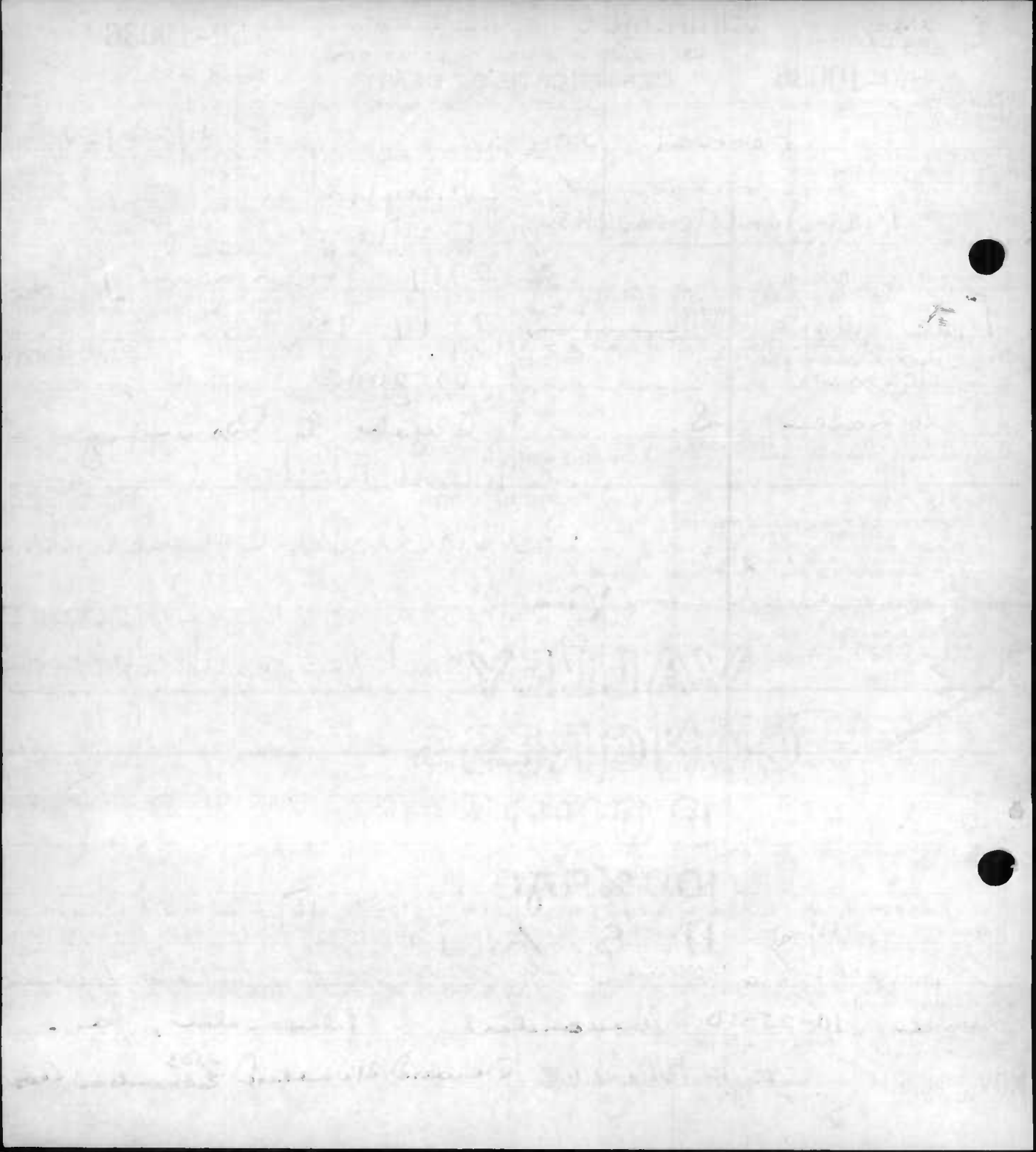
NOV 24 1950

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0466

MEDICAL CERTIFICATION



R-3040037

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHX 50-19037
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

NORMA JEAN Reed 544795

2. DATE OF DEATH NOV 24 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

JOHNS HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Md.

B. COUNTY Allegany

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Cumberland

D. STREET ADDRESS (If rural, give location)

420 Winmen St. 5102

c. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

female white

6. COLOR OR RACE

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

S.

8. DATE OF BIRTH

5-5-32

9. AGE (In years last birthday)

18

10. Under 1 Year Months: Days

11. Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Student

10B. KIND OF BUSINESS OR INDUSTRY

School

13. FATHER'S NAME

John Reed

14. MOTHER'S MAIDEN NAME

Olive Penner

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, or no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

None

17. INFORMANT ADDRESS

JOHNS HOPKINS HOSPITAL

18. 754.4 I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A)

aspiration pneumonia

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

Operation for

DUE TO

congenital heart disease, pulmonary stenosis

(C)

INTERVAL BETWEEN ONSET AND DEATH

7 d.

15 d.

Cong.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Congenital Syphilis

19A. DATE OF OPERATION

11-10-50

19B. MAJOR FINDINGS OF OPERATION

Pulmonic stenosis

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT WORK ☐NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11-14-, 1950 to 11-24-, 1950 that I last saw the deceased alive on 11-24-, 1950 and that death occurred at 12:10 A.M., from the causes and on the date stated above.

23A. SIGNATURE

J. B. Morrow

23B. ADDRESS

JOHNS HOPKINS HOSPITAL

23C. DATE SIGNED

11-24

M. D.

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

10-26-50

24C. NAME OF CEMETERY OR CREMATORY

Cumberland

24D. LOCATION (City, town, or county)

Cumberland, MD

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

Howard H. Hunsard 2503
Edmondson Ave

NOV 24 1950

VS 150

1572

MEDICAL CERTIFICATION

11-10-50

11-10-50

RECEIVED

NOV 10 1950

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J-525
50-10038BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50-10038
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Robert E. Johnson		2. DATE OF DEATH Nov. 19, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY X	
B. FULL NAME OF HOSPITAL OR INSTITUTION 1201 Coldspring Lane 2101		C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township) Baltimore 18-01	
C. Length of stay in Baltimore Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) 802 W. Lexington St.	
5. SEX Male	6. COLOR OR RACE Colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Dec. 25, 1882
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10B. KIND OF BUSINESS OR INDUSTRY Transfer Co.	9. AGE (In years last birthday) 67
13. FATHER'S NAME Unknown		11. BIRTHPLACE (State or foreign country) Michigan	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		12. CITIZEN OF WHAT COUNTRY? U.S. A.	
16. SOCIAL SECURITY NO.		14. MOTHER'S MAIDEN NAME Unknown	
17. INFORMANT M's Irene Johnson		ADDRESS 438 St. Mary St	

18. 334X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A)

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

INTERVAL BETWEEN ONSET AND DEATH

?

19A. DATE OF OPERATION 0		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Nov. 16, 1950, to Nov. 19, 1950, that I last saw the deceased alive on Nov. 16, 1950, and that death occurred at 930a m., from the causes and on the date stated above.					
26A. SIGNATURE R. E. Johnson		23B. ADDRESS 403 Med Arts Bldg		23C. DATE SIGNED 11-22-50	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-24-50		24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem.	
DATE RECEIVED BY VS 24 1950		REGISTRAR'S SIGNATURE Wm. Williams, Jr.		FURNERAL DIRECTOR Mrs. Frances H. Hensley	
VS 150		97052		083d	

578 W. Biddle St

STATE OF NEW YORK
IN SENATE

JANUARY 1, 1900. REPORT OF THE COMMISSIONERS OF THE LAND OFFICE.

ALBANY:
J. B. LEECH,
PRINTERS.
1900.

WILLIAM L. ALLEN,
GOVERNOR.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50-10039
Registered No.

BIRTH NO.

H-431-10039

1. NAME OF DECEASED (Type or Print) <u>Hildebrand, Laura</u>			2. DATE OF DEATH <u>Nov. 22, 1950</u>		
3. PLACE OF DEATH: A. <u>Baltimore City, Maryland Balto Md</u>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY		
5. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Joseph's</u>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <u>Baltimore</u>		
c. Length of stay in Baltimore <u>55 yr.</u>			D. STREET ADDRESS (If rural, give location) <u>3004 Du Boise Ave. 5200</u>		
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Sept. 15</u>		9. AGE (In years last birthday) <u>85</u> If Under 1 Year: Months: Days If Under 24 Hours: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <u>? Darr</u>			14. MOTHER'S MAIDEN NAME <u>Unknown</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS <u>Mrs. Marvin Ander 3126 Clearview Ave</u>		

18. E 900.01

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic cardio-vascular disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Hypostatic pneumonia

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C) Shock following a fall

CERTIFICATION APPROVED BY

Stanley B. Duda

19A. DATE OF OPERATION <u>0</u>		19B. MAJOR FINDINGS OF OPERATION		for: <u>C.J. Lubinski,</u> M. D. O. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) <u>Accident</u>	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) <u>home</u>	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>3004 Du Boise Avenue</u>			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>Nov. 18, 1950 8:25 p.m.</u>	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21F. HOW DID INJURY OCCUR? <u>Fell down stairs (inside)</u>			
22. I hereby certify that I attended the deceased from <u>Nov. 19,</u> 1950 to <u>Nov. 22, 1950</u> , that I last saw the deceased alive on <u>Nov. 21, 1950</u> , and that death occurred at <u>1:15 a.m.</u> , from the causes and on the date stated above.					
23A. SIGNATURE <u>G. G. Allee</u>		23B. ADDRESS M. O. <u>1100 N. Caroline St.</u>		23C. DATE SIGNED <u>Nov. 22, 1950</u>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>Nov. 24 50</u>	24C. NAME OF CEMETERY OR CREMATORY <u>Baltimore</u>	24D. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>		

DATE RECEIVED BY LOCAL REGISTRAR NOV 24 1950 REGISTRAR'S SIGNATURE William A. Williams, Jr. 25. FUNERAL DIRECTOR ADDRESS Paul A. Heemann 6067 Harford Rd.

10-10350

RECEIVED

10-10350



7-526

N.D.-1262650-10040

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50-10040
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Daniel Elwood(Elwood) Tankersley			2. DATE OF DEATH Nov. 22, 1950		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY		
B. FULL NAME OF HOSPITAL OR INSTITUTION Baltimore City Hospitals 4940 Eastern Avenue			C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township) Baltimore 18-02		
c. Length of stay in Baltimore 1 Year?			D. STREET ADDRESS (If rural, give location) 31 N. Carey St. ? (none)		
5. SEX M	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH Sept. 9, 1889	9. AGE (in years last birthday) 61 1/2	10. Under 1 Year Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) UNKNOWN		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Daniel Tankersley			14. MOTHER'S MAIDEN NAME Maria Gibson		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS Baltimore City Hospitals Records: 4940 Eastern Avenue		

18. 422.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) DUE TO (A) Cerebral Thrombosis (B) Arteriosclerosis, cerebral (C) Generalized arteriosclerotic cardiovascular disease	CAUSE OF DEATH	INTERVAL BETWEEN ONSET AND DEATH 2 wks years years
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION 2		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from 1-21, 1949, to 11-22, 1950, that I last saw the deceased alive on 11-22, 1950 and that death occurred at 12.05pm, from the causes and on the date stated above.				
23A. SIGNATURE J. P. O'Keefe	M. D.	23B. ADDRESS 4940 Eastern Avenue	23C. DATE SIGNED 11-23-50	

24A. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24B. DATE Nov. 25, 1950	24C. NAME OF CEMETERY OR CREMATORY WOODLAWN	24D. LOCATION (City, town, or county) (State) BALTIMORE, MD.
DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE Huntington Williams, M.D.	25. FUNERAL DIRECTOR ADDRESS WILLIAM COOK, INC 1217 ST. PAUL ST	

NOV 24 1950

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M-450

50-10041

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10041

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Catherine C. Mallonee

2. DATE
OF
DEATH

11/23/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Md.

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION

Franklin Square Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore 25-04

C. Length of stay in Baltimore

Yrs.
Mos.
Days

D. STREET ADDRESS (If rural, give location)

11 W. Jeffrey St.

5. SEX

Fe

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

widowed

8. DATE OF BIRTH

Jan. 4, 1877

9. AGE (In years
last birthday)

73

10. Under 1 Year
Months: Days11. Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Housework

10B. KIND OF BUSINESS OR
INDUSTRY

Home

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

James Hickey

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

None

17. INFORMANT

Family Sam

ADDRESS

18. 470.0

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A) Myocardial Infarction

18 hrs.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) Hypertensive heart disease, arteriosclerotic
basis

5-10 yrs

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

(C) Familial

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)22A. TIME (Month) (Day) (Year) (Hour)
OF INJURY

22B. INJURY OCCURRED

22C. HOW DID INJURY OCCUR?

m. WHILE AT WORK ☐ NOT WHILE
AT WORK ☐22. I hereby certify that I attended the deceased from Nov. 21, 1950, to Nov 23, 1950, that I last saw the
deceased alive on Nov 22, 1950, and that death occurred at 12:40 am., from the causes and on the date stated above.

23A. SIGNATURE

M. S. Ford

M. O.

23B. ADDRESS

130 S. Ford Ave. Baltimore

23C. DATE SIGNED

11-22-50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

11-25-50

24C. NAME OF CEMETERY OR CREMATORY

Spring Hill

24D. LOCATION (City, town, or county)

EASTON, MD.

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

James L. Hickey

ADDRESS

130 S. Ford Ave. 093d

NOV - 4 1950

VS 150

MEDICAL CERTIFICATION

STATE OF NEW YORK
CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
DATE OF BIRTH		PLACE OF BIRTH		MARRIED		OCCUPATION		EDUCATION		RELIGION	
CAUSE OF DEATH		MANNER OF DEATH		MEDICAL ATTENDANT		CORONER		BURIAL PLACE		DATE OF BURIAL	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESSES		SIGNATURE OF MEDICAL ATTENDANT		SIGNATURE OF CORONER		SIGNATURE OF BURIAL PLACE		SIGNATURE OF DATE OF BURIAL	

J-525
50-10042BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50-10042
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Rosie Johnson

2. DATE
OF
DEATH

Nov 22, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland Accident R.

B. FULL NAME OF
HOSPITAL OR
INSTITUTION (If not in hospital or institution, give street address or location)

JOHNS HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

MARYLAND

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

BALTIMORE

7-04

D. STREET ADDRESS (If rural, give location)

1523 E. CHASE ST.

c. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

FEMALE

6. COLOR OR RACE

COLORED

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

Widow

B. DATE OF BIRTH

7-18-1899

9. AGE (In years last birthday)

52

If Under 1 Year

Months: Days

If Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Md

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Wm Maddox

14. MOTHER'S MAIDEN NAME

Rosie Smith

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS

JOHNS HOPKINS HOSPITAL

18. 260X I

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) MYOCARDIAL INFARCTION

5 DAYS

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DIABETES MELLITUS

10 YRS.

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 6:10 am., from the causes and on the date stated above.

23A. SIGNATURE

Joseph Stokes III M. D.

23B. ADDRESS

JOHNS HOPKINS HOSPITAL

23C. DATE SIGNED

11-22-50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

11/26/50

24C. NAME OF CEMETERY OR CREMATORY

Mt. Calvary

24D. LOCATION (City, town, or county)

A. D. County, Md

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Thurston Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

Joseph B. Rocks, Jr. 1304 N. Central Ave

NOV 24 1950

061.0

MEDICAL CERTIFICATION

NOT A MEDICAL EXAMINER'S CASE

DR. CHESTER J. LUBINSKI

per: *St. On...* M.D.
CHIEF OR ASS'T. MEDICAL EXAMINER

0-242
50-10043BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50-10043

1. NAME OF DECEASED (Type or Print) CATHERINE OGCEBY		2. DATE OF DEATH 11/21/50	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MD.	
B. FULL NAME OF HOSPITAL OR INSTITUTION PROVIDENT		C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township) BALTIMORE 12-02	
D. LENGTH OF STAY IN BALTIMORE 14 yrs		E. STREET ADDRESS (If rural, give location) 2706 N HOWARD ST	
5. SEX Fe	6. COLOR OR RACE N	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) N	B. DATE OF BIRTH 1910
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H WIFE		10B. KIND OF BUSINESS OR INDUSTRY	
13. FATHER'S NAME WM ALEXANDRIA		14. MOTHER'S MAIDEN NAME MAHALIA RUCKER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		17. INFORMANT ADDRESS HOYT OGCEBY 2706 N. HOWARD ST	

18. 214 X I CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO

PULMONARY EMBOLISM

INTERVAL BETWEEN ONSET AND DEATH

1 HR

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

PELVIC THROMBOSIS

(C) DUE TO

FIBROMYOMATA UTERI

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION 11/9/50	19B. MAJOR FINDINGS OF OPERATION FIBROMYOMATA UTERI, OVARIAN CYST	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
---	--	----------------------------

22. I hereby certify that I attended the deceased from 11/7, 1950 to 11/21, 1950, that I last saw the deceased alive on 11/21, 1950, and that death occurred at 9:50 A. M., from the causes and on the date stated above.

23A. SIGNATURE M. E. Wilson / E. W. E. M. D.	23B. ADDRESS Provident Hospital	23C. DATE SIGNED 11/21/50
--	---------------------------------	---------------------------

24A. BURIAL, CREMATION, REMOVAL (Specify) Shipped	24B. DATE 11/24/50	24C. NAME OF CEMETERY OR CREMATORY Ellberton Georgia	24D. LOCATION (City, town, or county) (State)
DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE Huntington Williams, M.D.	25. FUNERAL DIRECTOR (Name) (Address) Dagner Sanders 0566	1412 E Preston St

NOV 24 1950

**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

50-10044

Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED
(Type or Print)

HARRY E. HUMPHREYS

2. DATE
OF
DEATH

Nov. 22, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland **1050 N. Milton Ave.**

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR INSTITUTION

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE

Md.

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore

D. STREET ADDRESS (If rural, give location)
1050 N. Milton Ave.

c. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

male

6. COLOR OR RACE

white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

married

8. DATE OF BIRTH

Nov. 24, 1878

9. AGE (In years last birthday)

71

72

10 Under 1 Year Months: Days

11 Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

retired - Linesman

10B. KIND OF BUSINESS OR INDUSTRY

C. & P. Tel. Co.

11. BIRTHPLACE (State or foreign country)

Montpelier, Vermont

12. CITIZEN OF WHAT COUNTRY?

U.S.

13. FATHER'S NAME

Henry Humphreys

14. MOTHER'S MAIDEN NAME

Albertine Bryan

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL SECURITY NO.

212-05-0549

17. INFORMANT

ADDRESS

Harry N. Humphreys, son, 3215 Roma Ave.

18.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) **Pulmonary Tuberculosis**
DUE TO

Prod
Dec. 3, 1948

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) _____
DUE TO

(C) _____

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **Dec. 3, 1948** to **Nov. 21, 1950**, that I last saw the deceased alive on **Nov. 21, 1950**, and that death occurred at **1 P.** m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

M. D.

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

Nov. 24, 1950

24C. NAME OF CEMETERY OR CREMATORY

Baltimore Cemetery

24D. LOCATION (City, town, or county) (State)

North Ave. & Rose St.

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

NOV 24 1950

Wilmington Williams, M.D.

**Schimmmer Funeral Home, Inc.
2801-4-5 E. Madison St.**

VS 150

540 JA

0136

MEDICAL CERTIFICATION

20-1004

DEPARTMENT OF DEATH

1004-1004

1004-1004

M-450

CERTIFICATE CORRECTED 11-28-50

M-6252-10045
BIRTH NO.BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50-10045

1. NAME OF DECEASED (Type or Print) Toni Maloni - ANTON MOROZEWICH			2. DATE OF DEATH Nov. 21, 1950		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY		
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals location) 4940 Eastern Avenue			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 21-02		
c. Length of stay in Baltimore 15 days ? Yrs. Mos. Days			D. STREET ADDRESS (If rural, give location) 1268 Glydon Ave. Glyndon		
5. SEX M	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) (-Single)	8. DATE OF BIRTH Not know		9. AGE (in years last birthday) 55
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sailor		10B. KIND OF BUSINESS OR INDUSTRY Clothing (M)	11. BIRTHPLACE (State or foreign country) Russian		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME ? Morozewich			14. MOTHER'S MAIDEN NAME Not know		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) —		16. SOCIAL SECURITY NO. 215-07-4068	17. INFORMANT Baltimore City Hospitals Records: 4940 Eastern Avenue		

18. 581.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) Cirrhosis of Liver DUE TO		INTERVAL BETWEEN ONSET AND DEATH Unknown
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO		
		(C) DUE TO		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED m. WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 11-6, 1950, to 11-21, 1950 that I last saw the deceased alive on 11-21, 1950, and that death occurred at 11.55am., from the causes and on the date stated above.				
23A. SIGNATURE J. D. Boyer		23B. ADDRESS 4940 Eastern Avenue		23C. DATE SIGNED 11-22-50

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial	24B. DATE Nov-25-50	24C. NAME OF CEMETERY OR CREMATORY Holy Trinity Russian	24D. LOCATION (City, town, or county) (State) Elkridge, Md
DATE RECEIVED BY LOCAL REGISTRAR NOV 24 1950	REGISTRAR'S SIGNATURE F. J. Williams, M.D.	25. FUNERAL DIRECTOR J. A. Grebliauckas, Jr. 1905 E. Pratt St.	

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C-623
50-10046BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50-10046
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) CLARENCE CROCKETT		2. DATE OF DEATH Nov. 23-50	
3. PLACE OF DEATH: A. Baltimore City, Maryland 646 W. FAYETTE		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE MARYLAND B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE 4-02	
c. Length of stay in Baltimore		D. STREET ADDRESS (If rural, give location) 646 W. FAYETTE ST.	
5. SEX MALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH AUG. 5-1900
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FIREMAN		10B. KIND OF BUSINESS OR INDUSTRY RAILROAD	9. AGE (In years last birthday) 50
11. BIRTHPLACE (State or foreign country) TANGIER, VA.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME WILLIAM H. CROCKETT		14. MOTHER'S MAIDEN NAME ALIZA J. BRUITT	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO. 219-07-4602	
17. INFORMANT MRS. ETHEL CROCKETT		ADDRESS 644 W. FAYETTE	

18. 42011 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Coronary Occlusion DUE TO Hypertensive Cardio-vascular disease DUE TO ?	CAUSE OF DEATH Coronary Occlusion Hypertensive Cardio-vascular disease ?	INTERVAL BETWEEN ONSET AND DEATH Sudden
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION 0		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Nov. 10, 1950 , to Nov 18, 1950 , that I last saw the deceased alive on Nov 18, 1950 , and that death occurred at 7 A.M. , from the causes and on the date stated above.					
23A. SIGNATURE Harry Shesman M. D.		23B. ADDRESS 753 W. Fayette St.		23C. DATE SIGNED Nov 24 50	
24A. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24B. DATE Nov 25-50		24C. NAME OF CEMETERY OR CREMATORY HOLY CROSS	
24D. LOCATION (City, town, or county) (State) BROOKLYN		DATE RECEIVED BY LOCAL REGISTRAR NOV 24 1950			
REGISTRAR'S SIGNATURE Washington Williams, M.D.		25. FUNERAL DIRECTOR J.A. Grebhauckar, Jr.		ADDRESS 1905 E. Pratt St.	

VS 150

542 50

093d

MEDICAL CERTIFICATION

Germany (Berlin) -
The main line from here

Jan 10 1911
528 4 1/2 p.m.
1911

Handwritten signature

R. 263

50-10047

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50-10047
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)A.
Harold Richards2. DATE
OF
DEATH

11/21/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

B. COUNTY

before admission)

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION

University Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

562 W. University Pkwy.

c. Length of stay in Baltimore

53

Yrs.
Mos.
Days

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

M

8. DATE OF BIRTH

2/15/1888

9. AGE (In years last birthday)

age 62

10. Under 1 Year
Months: Days:11. Under 24 Hours
Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Salesman

10B. KIND OF BUSINESS OR INDUSTRY

Self Employed
DRUGS (R)

11. BIRTHPLACE (State or foreign country)

Ind

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Charles C. Richards

14. MOTHER'S MAIDEN NAME

Ida Underbach

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Phy.

Mrs. Annette S. Richards 562 W. University

18. 410X

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

DUE TO

Coronary Infarct

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

Insufficiency

(C)

Rheumatic Heart Disease

INTERVAL BETWEEN
ONSET AND DEATHII
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT ☐ NOT WHILE
WORK AT WORK

22. I hereby certify that I attended the deceased from 11-14-50, 19__, to 11-20-50, 19__, that I last saw the deceased alive on 11-20-50, 19__ and that death occurred at 6:50 a.m., from the causes and on the date stated above.

23A. SIGNATURE

Joseph B. Bronushas

23B. ADDRESS

University Hospital

23C. DATE SIGNED

11/21/50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

Cremation

11-24-50

Green Mount

Baltimore

Md.

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Walter J. Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

John O. Mitchell & Sons 1900 E. Calver Pl.

VS 150

Joseph B. Bronushas 4906E

092 B

MEDICAL CERTIFICATION

73591-00

73591-00

73591-00

K-16050-10048

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50-10048
Registered No.C-113453
BIRTH NO. 216

1. NAME OF DECEASED (Type or Print) Joseph Kapera (Joseph Caspura)			2. DATE OF DEATH Nov. 21, 1950		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY		
B. FULL NAME OF HOSPITAL OR INSTITUTION Baltimore City Hospitals (location) 4940 Eastern Avenue			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore J-02		
c. Length of stay in Baltimore 5 Days ? Yrs. Mos. Days			D. STREET ADDRESS (If rural, give location) 828 S. Bond Street		
5. SEX M	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH 1888	9. AGE (In years last birthday) 62	10. Under 1 Year Months: Days: 11. Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10B. KIND OF BUSINESS OR INDUSTRY Farm	11. BIRTHPLACE (State or foreign country) Poland		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO. None	17. INFORMANT Baltimore City Hospitals Records: 4940 Eastern Avenue		

18. 477.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) Pulmonary Edema DUE TO	INTERVAL BETWEEN ONSET AND DEATH 48 hrs.
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) Arteriosclerotic Cardio Vascular Disease DUE TO	15 years
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		Pyelonephritis	5 yrs.

19A. DATE OF OPERATION 0		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 11-16, 1950, to 11-21, 1950, that I last saw the deceased alive on 11-21, 1950 and that death occurred at 10.20am from the causes and on the date stated above.					
23A. SIGNATURE W. Rogers M. D.		23B. ADDRESS 4940 Eastern Avenue		23C. DATE SIGNED 11-22-50	

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial	24B. DATE Nov. 25-50	24C. NAME OF CEMETERY OR CREMATORY Holy Rosary	24D. LOCATION (City, town, or county) (State) Baltimore Co. Md.
DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE Huntington Williams, M.D.	25. FUNERAL DIRECTOR Wm. S. Polkowski 2007 Eastern Ave	

OV 24 1950

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MEDICAL CERTIFICATION

8101-10

8101-10

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BALTIMORE CITY HEALTH DEPARTMENT

50-19049

Registered No.

BIRTH NO.

CERTIFICATE OF DEATH

1. NAME OF DECEASED
(Type or Print)

Raymond Jackson

2. DATE
OF
DEATH

Nov 23, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland HLH 4E

B. FULL NAME OF
HOSPITAL OR
INSTITUTION

JOHNS HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence
A. STATE B. COUNTY before admission)

MARYLAND

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

BALTIMORE

7-04

D. STREET ADDRESS (If rural, give location)

919 M'DONOUGH ST.

c. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

MALE

6. COLOR OR RACE

COLORED

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

SINGLE

8. DATE OF BIRTH

9-3-50

9. AGE (In years
last birthday)If Under 1 Year
Months: Days

2 20

If Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Md

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Willie Jackson

14. MOTHER'S MAIDEN NAME

Elizabeth Foster

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT ADDRESS

JOHNS HOPKINS HOSPITAL

18. 432.1 754.4

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, ashenia, etc. It means the disease,
injury or complication which caused death.)

(A) DUE TO

Auricular Flutter leading
into Acute Heart Failure

ANTECEDENT CAUSES

82 to 128 age 3

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) DUE TO
(C)II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
INJURY

21E. INJURY OCCURRED

m. WHILE AT ☐ NOT WHILE
WORK AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10-14, 1950, to 11-23, 1950, that I last saw the
deceased alive on 11-23, 1950, and that death occurred at 10 p.m., from the causes and on the date stated above.

23. SIGNATURE

Robert E. Gustafson M.D.

23B. ADDRESS

JOHNS HOPKINS HOSPITAL

23C. DATE SIGNED

24A. BURIAL, CREMA-
TION OR REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

NOV 24 1950

Huntington Williams, M.D.

Oliver O Wilson

157E

MEDICAL CERTIFICATION

Mr Tabata changed
code 433.1 to 754.4
5/21/51

F-450

Dr. Sawyer

4808 Harford Rd - 10050

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50-10050

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Martin Fallon

2. DATE
OF
DEATH

Nov. 24, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution; residence

A. STATE

Maryland

B. COUNTY

before admission)

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION

2638 Harford Road

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2638 Harford Road

C. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

male

6. COLOR OR RACE

white

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

widowed

8. DATE OF BIRTH

Jan. 29, 1876

9. AGE (In years;
last birthday)

74

10. Under 1 Year
Months Days11. Under 24 Hours
Hours Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Retired

10B. KIND OF BUSINESS OR
INDUSTRY

Constable Peoples Court

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Malachy Fallon

14. MOTHER'S MAIDEN NAME

Honora Mahoney

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Miss Mary Fallon, 2638 Harford Road

18. 420.0 and 177X
DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

CAUSE OF DEATH

(A) Broncho-pneumonia
DUE TO arteriosclerotic Heart
Disease
(B) Myocardial
DUE TO arteriosclerotic
(C) Carcinoma of ProstateINTERVAL BETWEEN
ONSET AND DEATH2 days
5 yrs.
8 yrs.
2 yrs.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 10, 1947, to Nov. 23, 1950, that I last saw the deceased alive on Nov 23, 1950, and that death occurred at 4 A. M., from the causes and on the date stated above.

23A. SIGNATURE

M. D.

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

11/27/50

24C. NAME OF CEMETERY OR CREMATORY

New Cathedral

24D. LOCATION (City, town, or county)

Baltimore, Md.

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Therese J. Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

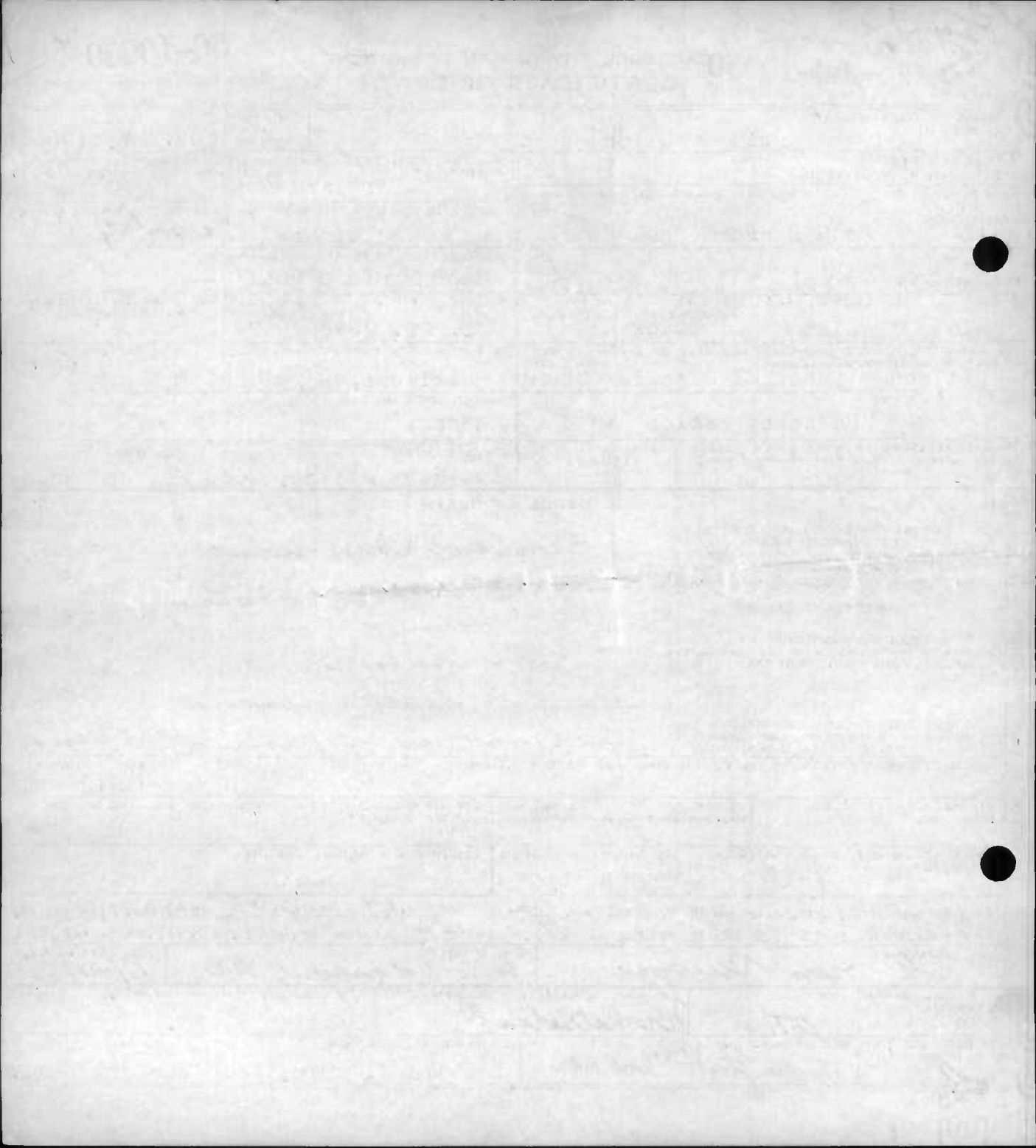
Leonard J. Ruck, 5305 Harford Road.

241950

77193

0516

MEDICAL CERTIFICATION



C-414

Dr. Colley

5103 Harford Rd

BALTIMORE CITY HEALTH DEPARTMENT

50-10051

Registered No.

BIRTH NO.

50-10051

CERTIFICATE OF DEATH

1. NAME OF DECEASED
(Type or Print)

Margaret A. Caulfield

2. DATE
OF
DEATH

Nov. 23, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence
before admission)

A. STATE

Maryland

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or
HOSPITAL OR location)
INSTITUTION

2808 White Avenue

C. CITY OR TOWN (If outside corporate limits, write RURAL and give
township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2808 White Avenue

c. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

female

6. COLOR OR RACE

white

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

widowed

8. DATE OF BIRTH

Apr. 29, 1860

9. AGE (In years,
last birthday)

90

10 Under 1 Year
Months: Days Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

at home

10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Richmond, Virginia

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Patrick Boyle

14. MOTHER'S MAIDEN NAME

Margaret A. Hagan

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL
SECURITY NO.17. INFORMANT ADDRESS
Mr. Clarence J. Caulfield, 6700 Harford

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A)

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?D. TIME (Month) (Day) (Year) (Hour)
INJURY

21E. INJURY OCCURRED

WHILE AT ☐
WORKNOT WHILE ☐
AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 1, 1949, to 11/23, 1950, that I last saw the
deceased alive on 19, and that death occurred at m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

11/25/50

24C. NAME OF CEMETERY OR CREMATORY

New Cathedral

24D. LOCATION (City, town, or county) (State)

Baltimore, Md.

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

NOV 24 1950

Leonard J. Ruck, 5305 Harford Road.

VS 150

093d

MEDICAL CERTIFICATION

Chronic Myocarditis
(Myocardial Infarction)

Specimen No. 11/23
Date 11/23/14

Dr. 5-5304508 Harford

BALTIMORE CITY HEALTH DEPARTMENT

50-10052

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

William Smith, Sr.

2. DATE
OF
DEATH

Nov. 23, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION

7303 Old Harford Road

Yrs.
Mos.
Days

C. Length of stay in Baltimore

4. USUAL RESIDENCE (Where deceased lived. If institution: residence
A. STATE B. COUNTY before admission)

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

27-7

D. STREET ADDRESS (If rural, give location)

7303 Old Harford Road

5. SEX

male

6. COLOR OR RACE

white

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

married

8. DATE OF BIRTH

Mar. 18, 1908

9. AGE (In years
last birthday)

42

10. Under 1 Year
Months: Days
11. Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Bricklayer

10B. KIND OF BUSINESS OR
INDUSTRY

CONST

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Wm. E. Smith

14. MOTHER'S MAIDEN NAME

Martha Eliason

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Evelyn Smith, 7303 Old Harford

18.

197X

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)(A) *Metastatic melanoma*
DUE TO *(Metastatic)*INTERVAL BETWEEN
ONSET AND DEATH

1 year

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

20. AUTOPSY?

YES ☐ NO ☒20. TIME (Month) (Day) (Year) (Hour)
INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1934, 1911-23-, 1950, that I last saw the
deceased alive on 11-20, 1950 and that death occurred at 10 P m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

G. W. Peake

M. D.

4508 Harford Road11-24-5024A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

11/27/50

24C. NAME OF CEMETERY OR CREMATORY

Baltimore National

24D. LOCATION (City, town, or county)

Fredrick Rd

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

11-21-50

Leonard J. Ruck, 5305 Harford Road.

WALLER
CONGRE
BOND
1955

**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

50-19053
Registered No.

BIRTH NO. 50-19053		1. NAME OF DECEASED (Type or Print) Eugene Lawrence Peters		2. DATE OF DEATH 11-22-50	
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE Snd. B. COUNTY Balt.		
B. FULL NAME OF (If not in hospital or institution, give street address or location) INSTITUTION Univ. Hosp.			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 27-03		
c. Length of stay in Baltimore			D. STREET ADDRESS (If rural, give location) 4916 Ross Rd., Balt 14, Snd		
5. SEX M	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH July 17, 1899	9. AGE (In years last birthday) 51	10. Under 1 Year Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) N.W. Baltimore City		10B. KIND OF BUSINESS OR INDUSTRY Police Dept		11. BIRTHPLACE (State or foreign country) Balt Md.	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME E.		14. MOTHER'S MAIDEN NAME Ella E.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Mrs Martha Peters - 4916 Ross	

18. 472.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Pulmonary Infarction		INTERVAL BETWEEN ONSET AND DEATH 20 hrs
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Cardiac Decompensation		3 wks
(B) Art. Sole Cardiac Circulation		5 yr
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION 0		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 11-3-50 19 50 , to 11-22-50 , 19 50 , that I last saw the deceased alive on 11-22 , 19 50 , and that death occurred at 1:40 p.m., from the causes and on the date stated above.					
23A. SIGNATURE W. H. Bannan M. D.		23B. ADDRESS Univ Hosp		23C. DATE SIGNED 11-	

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/25/50		24C. NAME OF CEMETERY OR CREMATORY Parkwood		24D. LOCATION (City, town, or county) (State) Balt Md	
DATE RECEIVED BY LOCAL REGISTRAR NOV 24 1950		REGISTRAR'S SIGNATURE William H. Bannan		25. FUNERAL DIRECTOR W. J. Luck		ADDRESS 5305 Harford 0930	

773 93

MEDICAL CERTIFICATION

**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

50-10054
Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED (Type or Print) FELDMAN, HARRY A. MILTON.		2. DATE OF DEATH 23 Nov 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland CHURCH HOME HOSP		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY _____	
B. FULL NAME OF HOSPITAL OR INSTITUTION CHURCH HOME HOSP.		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE 16 15-47	
c. Length of stay in Baltimore 52		D. STREET ADDRESS (If rural, give location) 2307 Poplar Grove	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE MARRIED WIDOWED MARRIED (Specify)	8. DATE OF BIRTH Dec 23 1896
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INSURANCE SALESMAN		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 54-53
11. BIRTHPLACE (State or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME JOSEPH FELDMAN		14. MOTHER'S MAIDEN NAME MINNIE BEARMAN.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NO		16. SOCIAL SECURITY NO. —	
17. INFORMANT PATIENT.		ADDRESS _____	

18. 420.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Coronary Thrombosis	CAUSE OF DEATH	INTERVAL BETWEEN ONSET AND DEATH 3 days
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) _____ (C) _____		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. II _____		

19A. DATE OF OPERATION 0	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **21 Nov 1950**, to **23 Nov 1950**, that I last saw the deceased alive on **23 Nov 1950**, and that death occurred at **11:44 a.m.**, from the causes and on the date stated above.

23A. SIGNATURE **Doreen Lensberg** M. D. 23B. ADDRESS **CHURCH HOME HOSPITAL** 23C. DATE SIGNED **Nov 23 1950**

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE Nov 23 1950	24C. NAME OF CEMETERY OR CREMATORY Hebrew Cemetery	24D. LOCATION (City, town, or county) (State) B. Allentown
DATE RECEIVED BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE Matthew Williams, M.D.	25. FUNERAL DIRECTOR David Frederickson ADDRESS 1802 E. State St

NOV 24 1950

45073

094a

MEDICAL CERTIFICATION

STATE OF TEXAS

COUNTY OF DALLAS

CITY OF DALLAS

IN SENATE

COMMISSIONERS

OF PUBLIC LANDS

AND

DEEDS

AND

RECORDS

OF

THE COUNTY OF DALLAS

X

STATE OF TEXAS

COUNTY OF DALLAS

COMMISSIONERS

OF PUBLIC LANDS

M-350
50-10055BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50-10055
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

ROBERT MOTEN

2. DATE
OF
DEATH

NOV 23, 50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF
HOSPITAL OR
INSTITUTION (If not in hospital or institution, give street address or location)

UNIVERSITY

Yrs.
Mos.
Days

C. Length of stay in Baltimore

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

MD.

B. COUNTY

FREDERICK

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

MT AIRY

D. STREET ADDRESS (If rural, give location)

6000

5. SEX

male

6. COLOR or RACE

col

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

married

8. DATE OF BIRTH

June 10.

9. AGE (in years
last birthday)

41

If Under 1 Year
Months: Days: Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR
INDUSTRY

Farm Labor

11. BIRTHPLACE (State or foreign country)

Leesburg Va

12. CITIZEN OF
WHAT COUNTRY?

Fredericks

13. FATHER'S NAME

John moten

14. MOTHER'S MAIDEN NAME

mollie

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

17. INFORMANT

John moten Father Recently

ADDRESS

18. 162X I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) BRONCHOGENIC CARCINOMA

DUE TO

INTERVAL BETWEEN
ONSET AND DEATH

8 m.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

11/20/50

3

19B. MAJOR FINDINGS OF OPERATION

BRONCHOGENIC CARCINOMA

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov 15, 1950, to Nov 23, 1950, that I last saw the deceased alive on Nov 23, 1950, and that death occurred at 5:55 A.m., from the causes and on the date stated above.

23A. SIGNATURE

Edmund B. Middleton

M. D.

23B. ADDRESS

University Hosp

23C. DATE SIGNED

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

Nov 26 1950

24C. NAME OF CEMETERY or CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

NOV 24 1950

REGISTRAR'S SIGNATURE

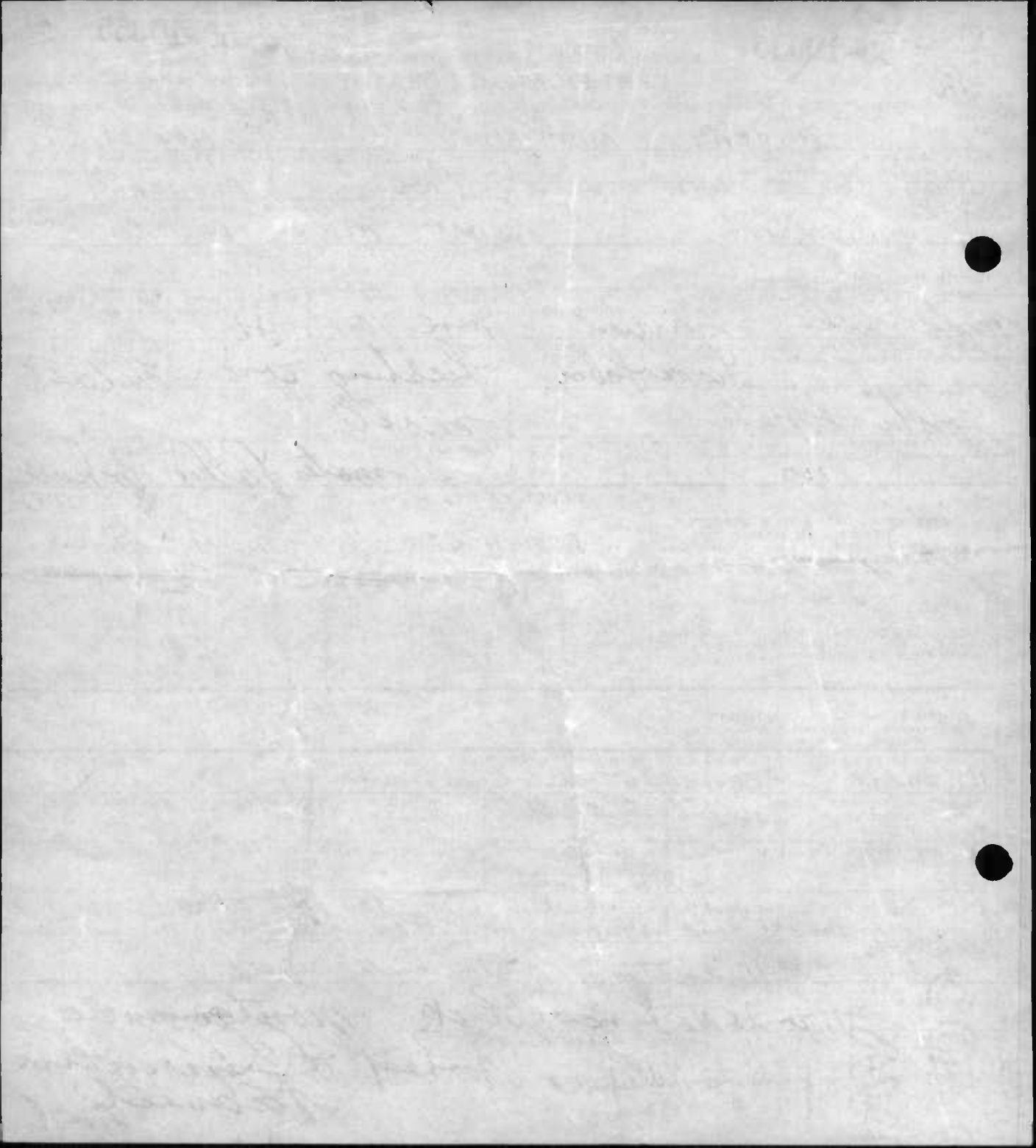
T. J. Williams, M.D.

UNIVERSITY DIRECTOR

Robert H. Broaden

ADDRESS

Fayetteville



G-653
50-10056

50-10056

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 3698

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>George H. Granderson</i>		2. DATE OF DEATH <i>Nov 23, 1950</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>md</i> B. COUNTY <i>16-02</i>			
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>1311 Harlem ave</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Balto</i>			
c. Length of stay in Baltimore <i>10 years</i>		D. STREET ADDRESS (If rural, give location) <i>1311 Harlem ave</i>			
5. SEX <i>m</i>	6. COLOR OR RACE <i>C</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>w</i>	8. DATE OF BIRTH <i>may 23, 1874</i>	9. AGE (in years last birthday) <i>76</i>	10. Under 1 Year Months: Days 11. Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>none</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>—</i>		11. BIRTHPLACE (State or foreign country) <i>Va</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Jefferson Granderson</i>		14. MOTHER'S MAIDEN NAME <i>Sarah Moody</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Eda L. Johnson</i>	
18. <i>422.2</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Myocarditis</i>		CAUSE OF DEATH (A) <i>Myocarditis</i> DUE TO (B) DUE TO (C) INTERVAL BETWEEN ONSET AND DEATH <i>Unknown</i>		19. ADDRESS <i>1311 Harlem ave</i>	
MEDICAL CERTIFICATION					
19A. DATE OF OPERATION <i>0</i>					
19B. MAJOR FINDINGS OF OPERATION					
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>9-18-</i> , 19 <i>50</i> , to <i>11-23-</i> , 19 <i>50</i> , that I last saw the deceased alive on <i>11-23-</i> , 19 <i>50</i> , and that death occurred at <i>6 P</i> m., from the causes and on the date stated above.					
23A. SIGNATURE <i>Frank A. Saunders</i>		23B. ADDRESS <i>1029 N. Strader St.</i>		23C. DATE SIGNED <i>11-24-50</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>11/26/50</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Glister</i>	
24D. LOCATION (City, town, or county) (State) <i>Glister Co, Va.</i>		24E. DATE RECEIVED BY LOCAL REGISTRAR <i>NOV 24 1950</i>		24F. REGISTRAR'S SIGNATURE <i>Wm. Williams</i>	
25. FUNERAL DIRECTOR <i>Wm. Williams</i>		25A. ADDRESS <i>1303</i>		25B. SIGNATURE <i>Presertman</i>	

100-1000

UNITED STATES DEPARTMENT OF THE INTERIOR

100-1000

[Faint, illegible handwritten text covering the majority of the page, likely bleed-through from the reverse side.]

P-500
50-10057BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50-10057
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) JOSEPH PAYNE			2. DATE OF DEATH Nov. 22, 1950		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY		
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) US Marine Hospital Wyman Pk. Drive & 31st St.			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 5-01		
c. Length of stay in Baltimore Yrs. Mos. Days			D. STREET ADDRESS (If rural, give location) 1210 Mc Elderry Court		
5. SEX M	6. COLOR OR RACE ool	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 12/1/03	9. AGE (In years last birthday) 46	10. Under 1 Year Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer			10B. KIND OF BUSINESS OR INDUSTRY Davis Chemical Co (M)		11. BIRTHPLACE (State or foreign country) Ga.
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME Nelson Payne		
14. MOTHER'S MAIDEN NAME Katie ?			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) ?		
16. SOCIAL SECURITY NO. ?			17. INFORMANT ADDRESS Records- US Marine Hospital, Balto, Md.		

18. 445X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
CAUSE OF DEATH
Malignant Hypertension at least 2 years

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION 0		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from Sept. 19 19 50, to Nov. 22 19 50 that I last saw the deceased alive on Nov. 22 19 50, and that death occurred at 8:45A m., from the causes and on the date stated above.

23A. SIGNATURE
E. D. Denton
M. D.

23B. ADDRESS
US Marine Hospital, Balto, Md.

23C. DATE SIGNED
11/22/50

24A. BURIAL, CREMATION, REMOVAL (Specify) Removal	24B. DATE Nov. 24/50	24C. NAME OF CEMETERY OR CREMATORY Plecco Georgia	24D. LOCATION (City, town, or county) (State) 102
DATE RECEIVED BY LOCAL REGISTRAR NOV 24 1950 VS 150		REGISTRAR'S SIGNATURE E. D. Denton	25. FUNERAL DIRECTOR Mrs. Robert G. Elliott & Daughter 11297. Caroline St.

9704R

CERTIFICATE OF DEATH

DATE OF DEATH

TIME OF DEATH

AGE

SEX

RACE

EDUCATION

1

RELATIONSHIP

CAUSE OF DEATH

IMMEDIATE CAUSE OF DEATH

UNDERLYING CAUSE OF DEATH

DATE OF DEATH

1

DATE OF DEATH

13-18

T-6150-10058

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHX 50-10058
Registered No.

BIRTH NO.			1. NAME OF DECEASED (Type or Print) <i>PIKS Lilly TRIBECK</i>			2. DATE OF DEATH <i>11-23-50</i>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Vicomicno</i>					
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>University Hopt.</i>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Salisbury, Route 1 Salisbury</i>					
C. Length of stay in Baltimore <i>29</i> Yrs. Mos. Days			D. STREET ADDRESS (If rural, give location) <i>Allen Road 7212</i>					
5. SEX <i>F</i>	6. COLOR OR RACE <i>N</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>MARRIED</i>	B. DATE OF BIRTH <i>1886</i>		9. AGE (in years last birthday) <i>64</i>	11. BIRTHPLACE (State or foreign country) <i>England</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>			10B. KIND OF BUSINESS OR INDUSTRY					
13. FATHER'S NAME <i>Edmund Brims</i>			14. MOTHER'S MAIDEN NAME <i>Beulah Irene Groom</i>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS		

18. <i>196 X</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) DUE TO <i>Carotid artery, primary & secondary? resulting in compression of spinal cord at level C6.</i>	CAUSE OF DEATH (A) <i>Carotid artery, primary & secondary?</i> (B) <i>resulting in compression of spinal cord at level C6.</i> (C) <i>Spinal Cord at level C6.</i>	INTERVAL BETWEEN ONSET AND DEATH <i>3 mo</i>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION <i>11-11-50</i>	19B. MAJOR FINDINGS OF OPERATION <i>Compression of spinal cord at C6, due to metastatic tumor</i>	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from <i>11-1-50</i> , 19 <i>50</i> , to <i>11-23</i> , 19 <i>50</i> , that I last saw the deceased alive on <i>11-23</i> , 19 <i>50</i> , and that death occurred at <i>2:30</i> p.m., from the causes and on the date stated above.		
23A. SIGNATURE <i>F.J. Borges</i>	23B. ADDRESS <i>University Hopt.</i>	23C. DATE SIGNED <i>11-24-50</i>
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>11-26-1950</i>	24C. NAME OF CEMETERY OR CREMATORY <i>Vicomicno</i>
24D. LOCATION (City, town, or county) <i>Salisbury Md</i>	24E. LOCATION (City, town, or county) (State) <i>Vicomicno Co Md</i>	
DATE RECEIVED BY LOCAL REGISTRAR <i>NOV 24 1950</i>	REGISTRAR'S SIGNATURE <i>Wilmington Williams, M.D.</i>	25. FUNERAL DIRECTOR ADDRESS <i>Halloway Co. Salisbury Md</i>

20-10012

20-10012



2-620

50-10059

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50-10059

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

JOSEPH DORSEY

2. DATE
OF
DEATH

NOV. 22, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF
HOSPITAL OR
INSTITUTION

JOHNS HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence
A. STATE B. COUNTY before admission)

MARYLAND

Baltimore

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

SYKESVILLE

D. STREET ADDRESS (If rural, give location)

337 Preston St 5600

c. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

MALE

6. COLOR OR RACE

COLORED

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

WIDOWED

8. DATE OF BIRTH

6-3-88

9. AGE (in years
last birthday)

62

If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during last of working life, even if retired)

Cook

10B. KIND OF BUSINESS OR
INDUSTRY

RETI.

11. BIRTHPLACE (State or foreign country)

Md

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Lou Bond

14. MOTHER'S MAIDEN NAME

J. Dorsey

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

JOHNS HOPKINS HOSPITAL

18. 4/30.0 and 002 X

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)(A) Subacute bacterial endo-
carditis

DUE TO

INTERVAL BETWEEN
ONSET AND DEATH

1 month

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

Pulmonary tuberculosis

?

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT WAS UNDER-
LYING OR CONTRIBUTING
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
INJURY

21E. INJURY OCCURRED

m.

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11-15 1950, to 11-22, 1950, that I last saw the
deceased alive on 11-22, 1950, and that death occurred at 1:00 a. m., from the causes and on the date stated above.

23A. SIGNATURE

Victor A. Mc Kusick M. O.

23B. ADDRESS

JOHNS HOPKINS HOSPITAL

23C. DATE SIGNED

Nov. 22, 1950

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

NOV 24 1950

Wilmington Williams, M.D.

Mrs Katie P. Williams Schwedens

62-1103

U.S. DEPT. OF JUSTICE

OFFICE OF THE ATTORNEY GENERAL

62-1103

10/10/54

RE: [illegible]
[illegible]

10/10/54

RE: [illegible]
[illegible]

T-520
50-10060BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10060

Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED
(Type or Print)

John Henry Thomas.

2. DATE
OF
DEATH

November 20, 1950.

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF
HOSPITAL OR
INSTITUTION (If not in hospital or institution, give street address or location)

1111 Shields Place

C. Length of stay in Baltimore

Yrs.
Mos.
Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland.

C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township)

Baltimore 17-02

D. STREET ADDRESS (If rural, give location)

1111 Shields Place.

5. SEX

male

6. COLOR OR RACE

C

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

married

8. DATE OF BIRTH

March 21, 1893

9. AGE (In years
last birthday)

57

If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR
INDUSTRY

Steel Plant (M)

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Thomas Thomas.

14. MOTHER'S MAIDEN NAME

?

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Mary W. Thomas. 1111 Shields Place

18. 443X I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) Chronic myocarditis

Several years

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

(C)

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.1. Hypertensive cardio-vascular
disease 2. Hemiplegia

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

D. TIME (Month) (Day) (Year) (Hour)
INJURY

21E. INJURY OCCURRED

M.

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 28, 1950, to November 20, 1950, that I last saw the deceased alive on Nov. 14, 1950, and that death occurred at 8:00 p. m., from the causes and on the date stated above.

23A. SIGNATURE

CR. Campbell

M. D.

23B. ADDRESS

718 Dolphin St.

23C. DATE SIGNED

11-24-50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

11-24-1950

24C. NAME OF CEMETERY OR CREMATORY

Balto. National Cem

24D. LOCATION (City, town, or county)

Balto

(State)

Md

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

[Signature]

25. FUNERAL DIRECTOR

Mrs. Katie R. Williams

ADDRESS

312 N Schroeder St

NOV 24 1950

VS 150

97034

093d

100-1000

UNITED STATES DEPARTMENT OF JUSTICE

OFFICE OF THE ATTORNEY GENERAL

100-1000

100-1000

100-1000



G-615
50-10061

50-10061

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED (Type or Print) BLANCHE GILBERT CORBIN		2. DATE OF DEATH NOVEMBER 23 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY _____	
B. FULL NAME OF HOSPITAL OR INSTITUTION 1125 WARD STREET		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE 21-02	
c. Length of stay in Baltimore 70 Yrs. Mths. Days		D. STREET ADDRESS (If rural, give location) 1125 WARD ST.	
5. SEX FEMALE	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED	8. DATE OF BIRTH MAY 5, 1880
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY own home	9. AGE (In years last birthday) 70
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ? GILBERT		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. _____	
17. INFORMANT George B. Corbin		ADDRESS 1136 WARD ST.	

18. 171X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Terminal Broncho pneumonia 4 days DUE TO Cancer of The Cervix unknown (squamous cell) with Metastases to liver & intestines	INTERVAL BETWEEN ONSET AND DEATH 4 days
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	

19A. DATE OF OPERATION 0		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from **October 1, 1950**, to **November 23, 1950**, that I last saw the deceased alive on **Nov 23, 1950**, and that death occurred at **12:10 P.m.**, from the causes and on the date stated above.

23A. SIGNATURE William N. Brulew M. D.	23B. ADDRESS 2030 W. Fayette St	23C. DATE SIGNED 11/23/50
---	---	-------------------------------------

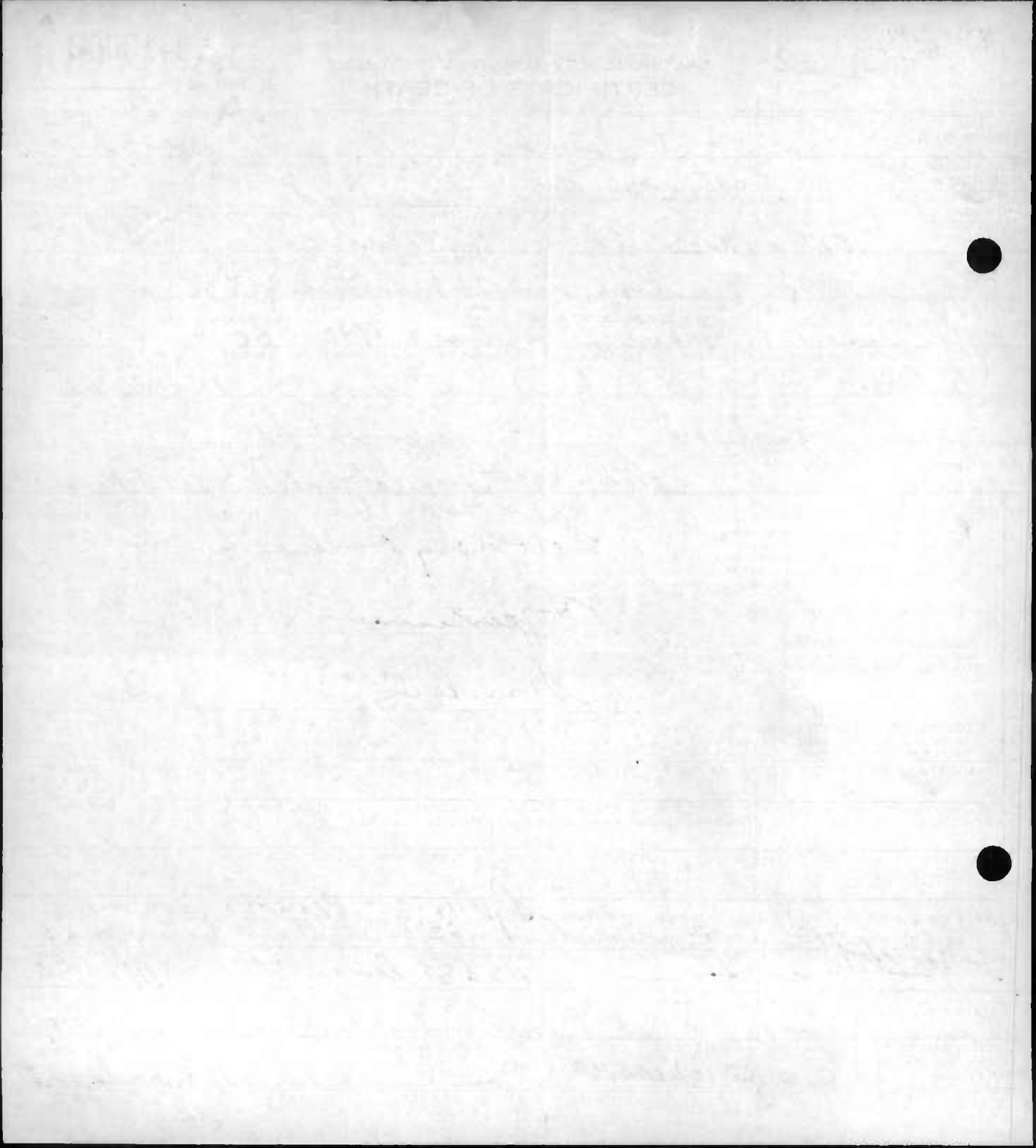
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial	24B. DATE 11/27/50	24C. NAME OF CEMETERY OR CREMATORY Baltimore Cem. E. North Ave. & Rose St.	24D. LOCATION (City, town, or county) (State) Baltimore Md.
DATE RECEIVED BY LOCAL REGISTRAR NOV 24 1950	REGISTRAR'S SIGNATURE Thurston Williams, M.D.	25. FUNERAL DIRECTOR John J. Cowan & Son ADDRESS 048a St.	

30-10061

CERTIFICATE OF DEATH
FALLING CITY, MISSOURI

30-10061

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES EARL RAY		MALE		35		JAN 5 1928		MOBILE, ALABAMA	
RACE		COLOR		RELIGION		MARRIAGE		OCCUPATION	
WHITE		WHITE		METHODIST		MARRIED		PUBLISHER	
EDUCATION		SCHOOLING		MILITARY SERVICE		RECORDS		REMARKS	
HIGH SCHOOL		12		NONE		NONE		DIED AT HOME	
PREVIOUS ILLNESS		CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH		DATE OF DEATH	
NONE		HEART DISEASE		SUICIDE		HOME		JAN 6 1963	
TENDERS		WITNESSES		CERTIFICATE		SIGNATURE		OFFICIAL	
NONE		NONE		NONE		NONE		NONE	



**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

50-10063
Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED (Type or Print) HENRY THORNTON			2. DATE OF DEATH November 19, 1950		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY _____		
B. FULL NAME OF HOSPITAL OR INSTITUTION 2047 Division Street			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 14-03		
C. Length of stay in Baltimore Yrs. _____ Mos. _____ Days _____			D. STREET ADDRESS (If rural, give location) 2047 Division Street		
5. SEX male	6. COLOR OR RACE colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) single	8. DATE OF BIRTH Jan. 31, 1907		
			9. AGE (In years last birthday) 43	10 Under 1 Year Months: _____ Days: _____	11 Under 24 Hours Hours: _____ Min: _____
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) cook			10B. KIND OF BUSINESS OR INDUSTRY club		
13. FATHER'S NAME George Thornton			11. BIRTHPLACE (State or foreign country) Free Union, Virginia		
			12. CITIZEN OF WHAT COUNTRY? _____		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no			16. SOCIAL SECURITY NO. 219-24-7634		
			14. MOTHER'S MAIDEN NAME Effie		
17. INFORMANT Wm. L. Boles (cousin)			ADDRESS 160-33 Claude Ave.		

18. E982X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH Stab wound of the anterior chest involving the pulmonary artery with hemopericardium and cardiac tamponade		INTERVAL BETWEEN ONSET AND DEATH _____
DUE TO (A) _____		
DUE TO (B) _____		
DUE TO (C) _____		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. _____		

19A. DATE OF OPERATION _____		19B. MAJOR FINDINGS OF OPERATION _____		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> CAUSE OF DEATH.		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) home		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Front room at 2047 Division Street	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY November 19, 1950 about 2p		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? common-law Stabbed during altercation with/wife	
22. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input checked="" type="checkbox"/> , undetermined <input type="checkbox"/> .					
23A. SIGNATURE <i>William V. ...</i>		23B. CHIEF MEDICAL EXAMINER..... M.D. ASSISTANT MEDICAL EXAMINER..... MEDICAL INVESTIGATOR.....		23C. DATE SIGNED Nov. 20, 1950	

24. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/24/50		24C. NAME OF CEMETERY OR CREMATORY Not Auburn	
24D. LOCATION (City, town, or county) (State) Baltimore Md		24E. DATE RECEIVED BY LOCAL REGISTRAR NOV 24 1950		25. FUNERAL DIRECTOR Chas. ...	
24F. REGISTRAR'S SIGNATURE <i>...</i>		24G. ADDRESS 512 ...		24H. ADDRESS ...	

VS 151 **N-861.2** **7548X** **167.0**

MEDICAL CERTIFICATION

P-360
50-10064BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10064

Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED (Type or Print) THEDA JOHANNAH POETTER		2. DATE OF DEATH Nov. 21, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE Maryland B. COUNTY _____	
B. FULL NAME OF HOSPITAL OR INSTITUTION 2709 N. Calvert Street		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore	
c. Length of stay in Baltimore Life		D. STREET ADDRESS (If rural, give location) 2709 N. Calvert Street	
5. SEX F	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widow	8. DATE OF BIRTH Jan. 1, 1874
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10B. KIND OF BUSINESS OR INDUSTRY Housewife	
13. FATHER'S NAME Richard Hidden		12. CITIZEN OF WHAT COUNTRY? USA	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mr. Wm. R. Potter		18. BIRTHPLACE (State or foreign country) Baltimore, Md.	
19. MOTHER'S MAIDEN NAME Katherine Agena		20. AGE (In years last birthday) 76	
21. Under 1 Year Months: Days		22. Under 24 Hours Hours: Min.	

18. **151X**

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)(A) **Carcinoma of the Stomach**
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) _____
DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C) _____

19A. DATE OF OPERATION October 1950		19B. MAJOR FINDINGS OF OPERATION Carcinoma of Stomach		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Sept 1, 1950 , to Nov 21, 1950 , that I last saw the deceased alive on Nov 21, 1950 , and that death occurred at 11 P. m. , from the causes and on the date stated above.					
23A. SIGNATURE Walter L. Senguer		23B. ADDRESS 11 E Chase St		23C. DATE SIGNED 11/22/50	
24A. BURIAL, CREMATION, REMOVAL (Specify) burial		24B. DATE 11/25/50		24C. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery	
DATE RECEIVED BY LOCAL REGISTRAR NOV 24 1950		REGISTRAR'S SIGNATURE Walter L. Senguer		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25. FUNERAL DIRECTOR HENRY SANDER & SONS, INC		ADDRESS BALTO., 13, MD.		26. SIGNATURE Henry T. Sander	

0466

1703-43

UNITED STATES DEPARTMENT OF THE INTERIOR

BUREAU OF LAND MANAGEMENT

WYOMING

TO THE SECRETARY OF THE INTERIOR
FROM THE DIRECTOR OF THE BUREAU OF LAND MANAGEMENT
SUBJECT: [Illegible]
[The following text is extremely faint and largely illegible due to the quality of the scan. It appears to be a memorandum or report detailing land management activities, possibly related to the 'WYOMING' header. Key words that are faintly visible include 'Bureau of Land Management', 'Department of the Interior', and 'Wyoming'. There are also some numbers and dates that are difficult to discern.]

G-622.
T-4580-10065BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50-10065
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Leo M. Groskowski- (Taylor)			2. DATE OF DEATH 11-23-50		
3. PLACE OF DEATH: A. Baltimore City, Maryland 5313 Edmonson Ave.			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Balto. B. COUNTY 1-05		
B. FULL NAME OF (If not in hospital or institution, give street address or location) Hood Convalescent Home 5313 Edmonson Ave. Balto., Md.			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)		
c. Length of stay in Baltimore Life			D. STREET ADDRESS (If rural, give location) 2202 E. Pratt Street		
5. SEX M	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 11-5-88	9. AGE (In years last birthday) 62	10. Under 1 Year Months: Days 11. Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant			10B. KIND OF BUSINESS OR INDUSTRY self		
13. FATHER'S NAME Felix Groskowski			14. MOTHER'S MAIDEN NAME Unknown		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
17. INFORMANT Gertrude Groskowski			ADDRESS 2202 E. Pratt Street		

18. **177X1**
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
Carcinoma of Prostate
CAUSE OF DEATH
(A) **Carcinoma of Prostate**
DUE TO
INTERVAL BETWEEN ONSET AND DEATH
2 yrs

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Aggravation C. & D.

19A. DATE OF OPERATION 11-19-50		19B. MAJOR FINDINGS OF OPERATION CAN/Prostate		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> HOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 11-16 19 50 , to 11-23 19 50 , that I last saw the deceased alive on 11-23 19 50 , and that death occurred at 1 A m., from the causes and on the date stated above.					
23A. SIGNATURE James E. Howes M. D.		23B. ADDRESS Baltimore		23C. DATE SIGNED 11-24	

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial	24B. DATE 11-25-50	24C. NAME OF CEMETERY OR CREMATORY Sacred Heart	24D. LOCATION (City, town, or county) (State) Baltimore Md.
DATE RECEIVED BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE William M. Williams	25. FUNERAL DIRECTOR Wolfe Street ADDRESS

NOV 24 1950

290

0516

Dr. Howell
715 Frederick Ave.
Catsville 4252.

543

50-10066

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10066

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

MABEL

REYNOLDS

2. DATE
OF
DEATH

November 23, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR INSTITUTION

Mercy Hospital

C. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Divorced

8. DATE OF BIRTH

Feb. 22 1904

9. AGE (In years
last birthday)

46

10. Under 1 Year
Months: Days11. Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Shoe Factory Worker

10B. KIND OF BUSINESS OR
INDUSTRY

(M)

11. BIRTHPLACE (State or foreign country)

Md

12. CITIZEN OF
WHAT COUNTRY?

U.S.

13. FATHER'S NAME

Harry Uhler

14. MOTHER'S MAIDEN NAME

Alice Bond

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Harry Uhler

Rustertown Md

18. E 812.4

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)(A) Multiple fractures of extremities,
pelvis, and clavicle

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B)
DUE TO
(C)OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or
about home, farm, factory, street, office bldg., etc.)

Street

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

Ensor Street & Ashland Avenue

10/2

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY
November 20, 1950 7:00P.m.21E. INJURY OCCURRED
WHILE AT WORK ☐ NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Pedestrian struck by auto

22. I certify that I took charge of the remains described above, held an Inspection & Inquiry thereon and from
Autopsy, Inspection or Inquiry
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,
and death in my opinion resulted from: natural causes ☐ accident ☒ suicide ☐ homicide ☐ undetermined ☐.

23A. SIGNATURE

23B. CHIEF MEDICAL EXAMINER.....
ASSISTANT MEDICAL EXAMINER.....
MEDICAL INVESTIGATOR.....

23C. DATE SIGNED

Nov. 24, 1950

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

Burial

Nov. 27-50

Emory Cem.

Balto Co.

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

NOV 24 1950

J. F. Williams, M.D.

J. F. Williams Rustertown Md.

VS 151

N 808.0

6904W

170C ✓

MEDICAL CERTIFICATION

424
50-19067BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50-19067
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

JAMES J. PLASSIL

2. DATE
OF
DEATH

Nov 22 1950

3. PLACE OF DEATH:

a. Baltimore City, Maryland

b. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR INSTITUTION

4706 Pk. Hghts ave

Yrs.
Mos.
Days

c. Length of stay in Baltimore

5. SEX

MALE

6. COLOR OR RACE

WHITE

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

1883

9. AGE (In years

last birthday)

67

11 Under 1 Year

Months: Days

11 Under 24 Hours

Hours: Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

Retired

Butcher - saw Balto. md

13. FATHER'S NAME

Martin Plasil

14. MOTHER'S MAIDEN NAME

Annie Kolmazyk

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Mrs Adew B. Crofoot, 4706 Pk. Hghts ave

18. 420.0

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) ARTERIO SCLEROTIC HEART DISEASE

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY

21e. INJURY OCCURRED

m.

WHILE AT WORK ☐NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐.

23a. SIGNATURE

Russell S Fisher

M.D.

23b. CHIEF MEDICAL EXAMINER ☒ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐

23c. DATE SIGNED

Nov 23, 1950

24a. BURIAL, CREMATION, REMOVAL (Specify)

24b. DATE

Nov 25 1950

24c. NAME OF CEMETERY OR CREMATORY

Oak Hill

24d. LOCATION (City, town, or county)

Phila Rd. Balto. md

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

Harry H. Witke, 4101 Edmond

NOV 24 1950

VS 151

6446A

93D Ave

MEDICAL CERTIFICATION

62-1037

MINIMUM DATA REPORT
CERTIFICATE OF DEATH

62-1037

James P. ...

James P. ...

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362
50-10068Dietrich
BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50-10068
Registered No.

BIRTH NO.	
1. NAME OF DECEASED (Type or Print) <i>Michael Dietrich</i>	
2. DATE OF DEATH <i>11/23/50</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland	
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>md.</i> B. COUNTY <i>Baltimore</i>	
5. FULL NAME OF (If not in hospital or institution, give street address or location) <i>St. Agnes Hospital</i>	
6. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Balt. in WESTLAND</i>	
7. STREET ADDRESS (If rural, give location) <i>4753 Westland Blvd. 5210</i>	
8. DATE OF BIRTH <i>11-27</i>	
9. AGE (in years last birthday) <i>73</i>	
10. CITIZEN OF WHAT COUNTRY? <i>Germany</i>	
11. BIRTHPLACE (State or foreign country)	
12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Henry</i>	
14. MOTHER'S MAIDEN NAME <i>Elizabeth Werich</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <i>053-10-8294</i>	
17. INFORMANT <i>John J. Dietrich</i> ADDRESS <i>4753 Westland Blvd</i>	
18. <i>420.1</i> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) <i>ACUTE CORONARY</i> DUE TO <i>OCCLUSION</i> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO (C) II OTHER SIGNIFICANT CONDITIONS CON- TRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	
19A. DATE OF OPERATION <i>0</i>	
19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDER- LYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>11/23</i> , 19 <i>50</i> , to <i>11/23</i> , 19 <i>50</i> , that I last saw the deceased alive on <i>11/23</i> , 19 <i>50</i> , and that death occurred at <i>7:10</i> m., from the causes and on the date stated above.	
23A. SIGNATURE <i>John H. Shaw</i> M. D.	
23B. ADDRESS <i>St. Agnes Hosp.</i>	
23C. DATE SIGNED <i>11/20/50</i>	
24A. BURIAL, CREMA- TION, REMOVAL (Specify) <i>BURIAL</i>	
24B. DATE <i>11/25/50</i>	
24C. NAME OF CEMETERY OR CREMATORY <i>Cathedral</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore</i>	
DATE RECEIVED BY LOCAL REGISTRAR <i>NOV 24 1950</i>	
REGISTRAR'S SIGNATURE <i>William Williams</i>	
25. FUNERAL DIRECTOR <i>M. Fahy & Sons</i> ADDRESS <i>401 Suffolk Rd.</i>	
VS 150 <i>754 6M</i> <i>94a</i>	

2001-02

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10/10/01

451
50-10069BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50-10069

1. NAME OF DECEASED (Type or Print) Rudolph A. Malinofski		2. DATE OF DEATH Nov. 21, 1950.	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY 20-05	
B. FULL NAME OF HOSPITAL OR INSTITUTION 311 S. Smallwood St.		C. CITY OR TOWN (If outside corporate limits, write (U.R.A.) and give township) Baltimore	
c. Length of stay in Baltimore Life		D. STREET ADDRESS (If rural, give location) 311 S. Smallwood St.	
5. SEX Male	6. COLOR OR RACE W.	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH July 24, 1892
9. AGE (In years: last birthday) 58		10. Under 1 Year: Months: Days 11. Under 24 Hours: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman		10B. KIND OF BUSINESS OR INDUSTRY Baltimore City Parks Balto. Md.	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Malinofski		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Annie Malinofski, 311 S. Smallwood St.		ADDRESS	
18. 4201 CAUSE OF DEATH			
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) (A) Hypertension Arteriosclerosis DUE TO			
II ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) Coronary Thrombosis (Acute) DUE TO			
(C) Cardiovascular Disease			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		CERTIFICATION APPROVED BY R. S. Fisher M. D.	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 11-21-50 , 19 50 , to 11-21-50 , 19 50 , that I last saw the deceased alive on 11-21-50 , 19 50 , and that death occurred at 6:45 PM , from the causes and on the date stated above.			
23A. SIGNATURE Edward J. Krieg M.D.		23B. ADDRESS 4508 Edmondson Village	
23C. DATE SIGNED 24 Nov 50			
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial	24B. DATE Nov. 25/50	24C. NAME OF CEMETERY OR CREMATORY Loudon Park, 3801 Frederick Rd. Balto. Md.	24D. LOCATION (City, town, or county) (State) Baltimore, Md.
DATE RECEIVED BY LOCAL REGISTRAR NOV 25 1950		REGISTRAR'S SIGNATURE Harry H. Wright	
VS 150 Cleared by Dr. Fisher 523 93		25 FUNERAL DIRECTOR Harry H. Wright	
		ADDRESS 4101 Edmondson Ave.	

93D

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DEPARTMENT OF HEALTH

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520
50-10070

50-10070

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. _____

BIRTH NO.		1. NAME OF DECEASED (Type or Print) Laura J. Banks		2. DATE OF DEATH Nov. 23, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 16-01			
B. FULL NAME OF HOSPITAL OR INSTITUTION 616 N. Carrollton Ave.		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore			
c. Length of stay in Baltimore		D. STREET ADDRESS (If rural, give location) 616 N. Carrollton Ave.			
5. SEX Female	6. COLOR OR RACE Colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widow	8. DATE OF BIRTH Nov. 10, 1886	9. AGE (In years last birthday) 64	If Under 1 Year Months: Days If Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia	
13. FATHER'S NAME George Epps		12. CITIZEN OF WHAT COUNTRY? U. S. A.		14. MOTHER'S MAIDEN NAME Lucy Ann	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Mrs. Mary Myers 616 N. Carrollton Av	
18. 442X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) Cardio renal vascular disease ? DUE TO (B) chronic nephritis ? DUE TO (C) multinodular uterine fibroid ?		INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION 0		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 5.15.1950 , 19 50 , to 11.23.1950 , 19 50 , that I last saw the deceased alive on 11.21.1950 , and that death occurred at 5:30 A.M. , from the causes and on the date stated above.					
23A. SIGNATURE James M. Fair		23B. ADDRESS 400 N. Carrollton Ave		23C. DATE SIGNED 11.24.1950	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-25-50		24C. NAME OF CEMETERY OR CREMATORY Dinwiddie, Virginia.	
DATE RECEIVED BY LOCAL REGISTRAR NOV 25 1950		REGISTRAR'S SIGNATURE Washington Williams, M.D.		25. FUNERAL DIRECTOR ADDRESS Mrs. Trause T. Hemeley 578 W. Biddle St.	

MEDICAL CERTIFICATION

131a

00001-02

THE NATIONAL ARCHIVES

COLLECTION OF LETTERS

00001-02

WALLEY'S
CONGRUENTS
BOMB
100% HAG
J. S.

455
50-10071

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10071

Registered No.

1. NAME OF DECEASED (Type or Print) SARAH A. KILLMON.			2. DATE OF DEATH Nov 21, 1950		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Ind. B. COUNTY 13-08		
B. FULL NAME OF HOSPITAL OR INSTITUTION 1511 Union Ave.			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto		
c. Length of stay in Baltimore Yrs. Mos. Days			D. STREET ADDRESS (If rural, give location) 1511 Union Ave.		
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH May 22, 1870	9. AGE (In years last birthday) 80	If Under 1 Year Months: Days If Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none			10B. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Ind.
12. CITIZEN OF WHAT COUNTRY? ?			13. FATHER'S NAME ?		
14. MOTHER'S MAIDEN NAME ?			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) -		
16. SOCIAL SECURITY NO. -			17. INFORMANT ADDRESS John Killmon 1511 Union Ave.		
18. 331X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) cerebral hemorrhage DUE TO (A) (B) Arteriosclerosis DUE TO (C) INTERVAL BETWEEN ONSET AND DEATH 1 day unknown			CAUSE OF DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0			19B. MAJOR FINDINGS OF OPERATION		
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Jan 15, 1950 to Nov 21, 1950 , that I last saw the deceased alive on Nov 20, 1950 , and that death occurred at 9:12 p.m. , from the causes and on the date stated above.					
23A. SIGNATURE Nathan Roever		23B. ADDRESS M. D. 206 S. Gilman St.		23C. DATE SIGNED 11-22-50	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE Nov 25/50		24C. NAME OF CEMETERY OR CREMATORY Iny Hill	
24D. LOCATION (City, town, or county) (State) Laurel, Ind.					
DATE RECEIVED BY LOCAL REGISTRAR NOV 25 1950		REGISTRAR'S SIGNATURE Anthony T. Williams, M.D.		25. FUNERAL DIRECTOR ADDRESS Paul C. Schenck, 3615-17 Chestnut Ave.	

MEDICAL CERTIFICATION

15001-100

THE UNIVERSITY OF CHICAGO
LIBRARY

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[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page. The text appears to be organized into several paragraphs.]

35
0-10072BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50-10072

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

GERNAVUS M. FORTMILLER

2. DATE
OF
DEATH

23 Nov. 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION

Union Memorial Hospital

C. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

8 June 1890

9. AGE (In years

last birthday)

60

If Under 1 Year

Months: Days

If Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Pres. Lawrence Elderbrook Co.

10B. KIND OF BUSINESS OR INDUSTRY

KITCHEN UTENSILS

11. BIRTHPLACE (State or foreign country)

Balt. Md

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

John Fortmiller

14. MOTHER'S MAIDEN NAME

Rosa France

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

Unknown

16. SOCIAL SECURITY NO.

215-09-4996

17. INFORMANT

Mrs. Mamie Fortmiller
Patient's wife same

18. 443X

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

Cerebral Hemorrhage
Cerebrovascular Accident

DUE TO

INTERVAL BETWEEN ONSET AND DEATH

5 days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

Hypertensive Cardiovascular Disease

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

None

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 21 Nov., 1950, to 23 Nov., 1950, that I last saw the deceased alive on 23 Nov., 1950, and that death occurred at 11:00 P.M., from the causes and on the date stated above.

23A. SIGNATURE

Richard Beach

M. D.

23B. ADDRESS

Union Memorial H.

23C. DATE SIGNED

11-23-50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

Nov. 27, 1950

24C. NAME OF CEMETERY OR CREMATORY

Baltimore Cemetery

24D. LOCATION (City, town, or county)

Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR

NOV 25 1950

REGISTRAR'S SIGNATURE

L. H. Williams, M.D.

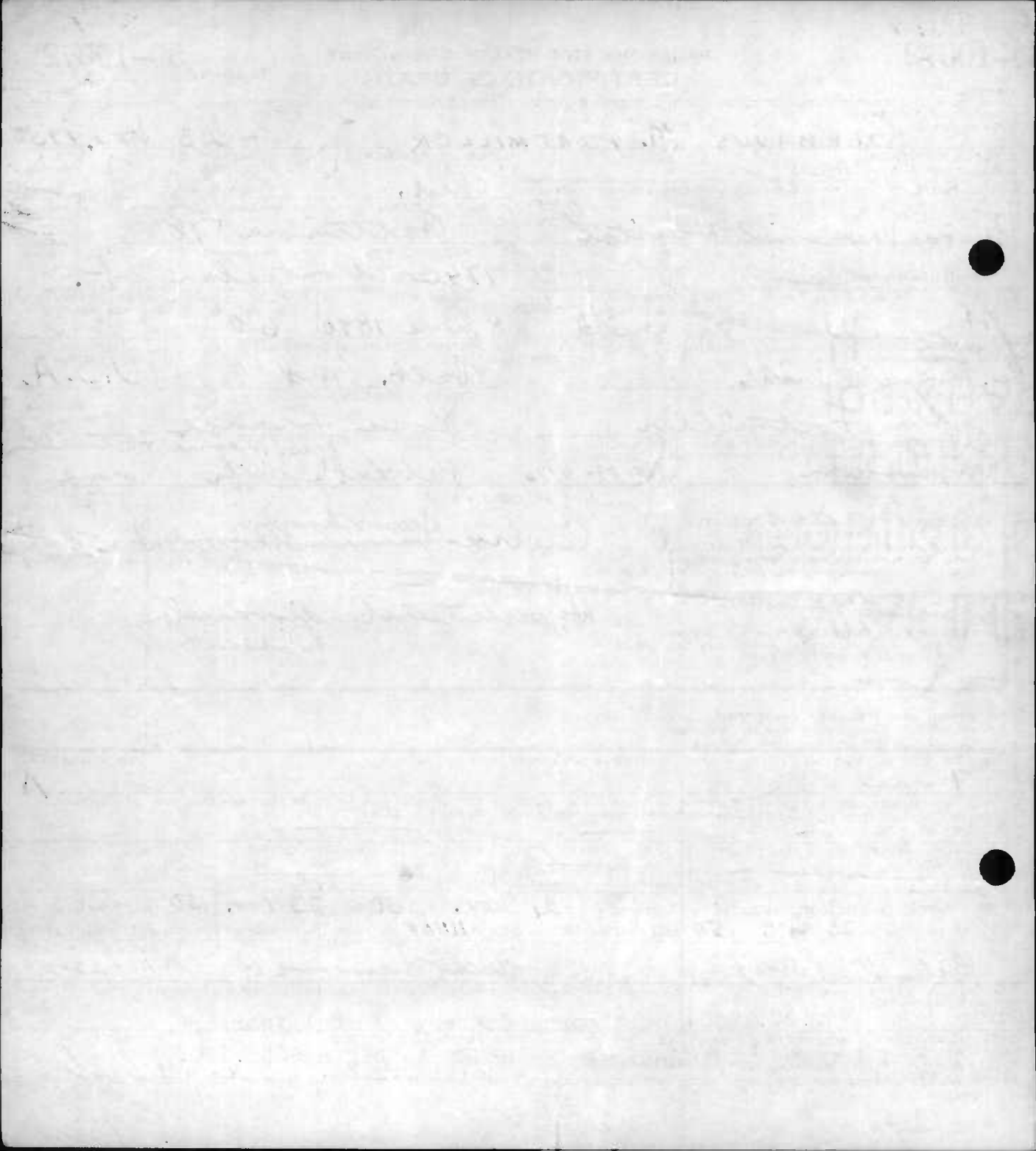
25. FUNERAL DIRECTOR

HENRY SANDER & SONS, INC.

Baltimore Md.

ADDRESS

Seymour A. Sander



BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10073

Registered No.

1. NAME OF DECEASED (Type or Print) <i>Lawrence Stevens</i>		2. DATE OF DEATH <i>Nov. 21, 1950</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <i>N. Suss Hall 7</i>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence A. STATE <i>Md.</i> B. COUNTY <i>Baltimore</i> before admission)	
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>JOHNS HOPKINS HOSPITAL</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore</i>	
D. STREET ADDRESS (If rural, give location) <i>Box 331 Rt 14</i>			
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>	
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Married</i>		8. DATE OF BIRTH <i>7-13-82</i>	
9. AGE (in years last birthday) <i>68</i>		10. Under 1 Year Months: Days	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Warren Stevens</i>		14. MOTHER'S MAIDEN NAME <i>Mollie Jackson</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>none</i>	
17. INFORMANT <i>Mrs. Mary J. Stevens</i>		ADDRESS <i>Box 331 Rosewood Pl. Md.</i>	
18. <i>E900.0</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH <i>Head Injury</i>		INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) <i>Angina Pectoris</i>		CERTIFICATION APPROVED BY <i>DR. JOHN R. DAVIS</i> <i>Per. J. H. Denecker</i> M. D. CHIEF OR ASST. MEDICAL EXAMINER	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Angina Pectoris</i>		<i>8 yrs</i>	
19A. DATE OF OPERATION <i>None</i>	19B. MAJOR FINDINGS OF OPERATION <i>None performed</i>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) <i>Home</i>	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <i>Baltimore</i>	
21D. TIME (Month) (Day) (Year) (Hour) <i>Nov. 18 1950</i>	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21F. HOW DID INJURY OCCUR? <i>Fell down steps</i>	
22. I hereby certify that I attended the deceased from <i>11-18-</i> 19 <i>50</i> to <i>11-20-</i> 19 <i>50</i> , that I last saw the deceased alive on <i>11-20</i> , 19 <i>50</i> , and that death occurred at <i>3:05 P.M.</i> , from the causes and on the date stated above.			
23A. SIGNATURE <i>George G. Culbreth</i>		23B. ADDRESS <i>JOHNS HOPKINS HOSPITAL</i>	23C. DATE SIGNED <i>Nov. 21 1950</i>
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i>	24B. DATE <i>11/25/50</i>	24C. NAME OF CEMETERY OR CREMATORY <i>Lorraine Park Cem.</i>	24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>
DATE RECEIVED BY LOCAL REGISTRAR <i>NOV 25 1950</i>	REGISTRAR'S SIGNATURE <i>W. H. Williams, Jr.</i>	25. FUNERAL DIRECTOR ADDRESS <i>HENRY SANDER & SONS, INC. BALTO., 13, MD. See H. Sander</i>	

MEDICAL CERTIFICATION

VS 150
Certificate to be approved by Medical Examiner
N 856.0
7393
186a

55-1113

82

RECEIVED BY

DATE

TIME

BY

INITIALS

REMARKS

DATE

TIME

BY

INITIALS

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DATE

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INITIALS

REMARKS

DATE

TIME

BY

INITIALS

160

50-10074

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10074

Registered No.

1. NAME OF DECEASED (Type or Print) CARROLL OPPER		2. DATE OF DEATH Nov. 21, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY	
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR US Marine Hospital INSTITUTION Wyman Pk. Drice & 31st St.		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore	
c. Length of stay in Baltimore ? Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) 824 W. Fairmount Avenue	
5. SEX M	6. COLOR OR RACE col.	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Wid.	8. DATE OF BIRTH 4/13/83
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Junk Dealer (not recently)		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME George Opper		14. MOTHER'S MAIDEN NAME Nancy ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) ?		16. SOCIAL SECURITY NO. ?	
17. INFORMANT ADDRESS Records- US Marine Hospital, Balto, Md.			

18. 151X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH Carcinoma of Stomach with metastases to Liver INTERVAL BETWEEN ONSET AND DEATH unknown	(A) DUE TO	(B) DUE TO	(C)
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			

19A. DATE OF OPERATION ?		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Oct. 2 , 1950, to Nov. 21 , 1950, that I last saw the deceased alive on Nov. 21 , 1950, and that death occurred at 5:49 P.m. , from the causes and on the date stated above.					
23A. SIGNATURE E. D. Dent, Jr.		23B. ADDRESS US Marine Hospital, Balto, Md.		23C. DATE SIGNED 11/22/50	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-25-1950		24C. NAME OF CEMETERY OR CREMATORY St. Luke's Cem.	
24D. LOCATION (City, town, or county) Balto.		24E. STATE Md.		25. FUNERAL DIRECTOR Wm. R. Williams	
DATE RECEIVED BY LOCAL REGISTRAR NOV 25 1950		REGISTRAR'S SIGNATURE Wm. R. Williams		ADDRESS 322	

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**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

50-10075
Registered No. _____

324
50-10075

1. NAME OF DECEASED (Type or Print) THOMAS B RADCLIFFE			2. DATE OF DEATH 11-24-50		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE MARYLAND B. COUNTY HOWARD		
B. FULL NAME OF HOSPITAL OR INSTITUTION UNIV HOSP.			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) ELLICOTT CITY		
c. Length of stay in Baltimore Yrs. 4 Mos. 4 Days 4			D. STREET ADDRESS (If rural, give location) W. MAIN ST. 6300		
5. SEX MA	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH 1869		9. AGE (In years last birthday) 81
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED PAINTER		10B. KIND OF BUSINESS OR INDUSTRY HOUSE	11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? W
13. FATHER'S NAME SAVIER RADCLIFFE			14. MOTHER'S MAIDEN NAME MARTHA GOSWELL		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. NONE		17. INFORMANT HOP. Records	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. NONE		ADDRESS	

18. 443X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH
(A) HYPERTENSIVE CARDIOVASCULAR DISEASE DUE TO DISEASE		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) _____ DUE TO _____		
(C) GENERALIZED ATHEROSCLEROSIS		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION 0		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED m. WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 11-20 , 19 50 , to 11-24 , 19 50 , that I last saw the deceased alive on 11-24 , 19 50 , and that death occurred at 12:00 PM , from the causes and on the date stated above.					
23A. SIGNATURE John W. Stoner		23B. ADDRESS Univ. Hosp.		23C. DATE SIGNED 11-24-50	
24A. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24B. DATE 11-27-50	24C. NAME OF CEMETERY OR CREMATORY ST. JOHNS		24D. LOCATION (City, town, or county) (State) ELLICOTT CITY Md.	
DATE RECEIVED BY LOCAL REGISTRAR NOV 25 1950		REGISTRAR'S SIGNATURE W. J. Williams, M.D.		25. FUNERAL DIRECTOR F. P. HIGINBOTHAM, ELLICOTT CITY Md.	

MEDICAL CERTIFICATION

937

50-10000

RECEIVED

1971



653
50-10076
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10076

Registered No.

1. NAME OF DECEASED (Type or Print) Harry G. Prentiss		2. DATE OF DEATH Nov. 24, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION 634 Gorsuch Ave.		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore	
c. Length of stay in Baltimore Life		D. STREET ADDRESS (If rural, give location) 634 Gorsuch Ave	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH May 2, 1858
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Medical Doctor		10B. KIND OF BUSINESS OR INDUSTRY Medicine	9. AGE (In years last birthday) 92
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Samuel Prentiss		14. MOTHER'S MAIDEN NAME Susan ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Miss Annette Prentiss		ADDRESS 634 Gorsuch Ave.	

18. 605x DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Cyphitis + pyuria DUE TO pyuria		INTERVAL BETWEEN ONSET AND DEATH 1 year
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION 0		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE <input type="checkbox"/> AT WORK	21F. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from Nov. 18, 1950 , to Nov. 22, 1950 , that I last saw the deceased alive on Nov. 22, 1950 , and that death occurred at m. , from the causes and on the date stated above.				
23A. SIGNATURE John Strickler Jr.		23B. ADDRESS 632 4th Ave.	23C. DATE SIGNED Nov 25 1950	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial	24B. DATE 11/27/50	24C. NAME OF CEMETERY OR CREMATORY Greenmount	24D. LOCATION (City, town, or county) (State) Baltimore, Maryland.	
DATE RECEIVED BY LOCAL REGISTRAR NOV 25 1950		REGISTRAR'S SIGNATURE John Strickler Jr.	25. FUNERAL DIRECTOR W. J. Thomas and Son 305 N. Calvert	

VS 150

(H. Strickler Jr. M.D.)

135a

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**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

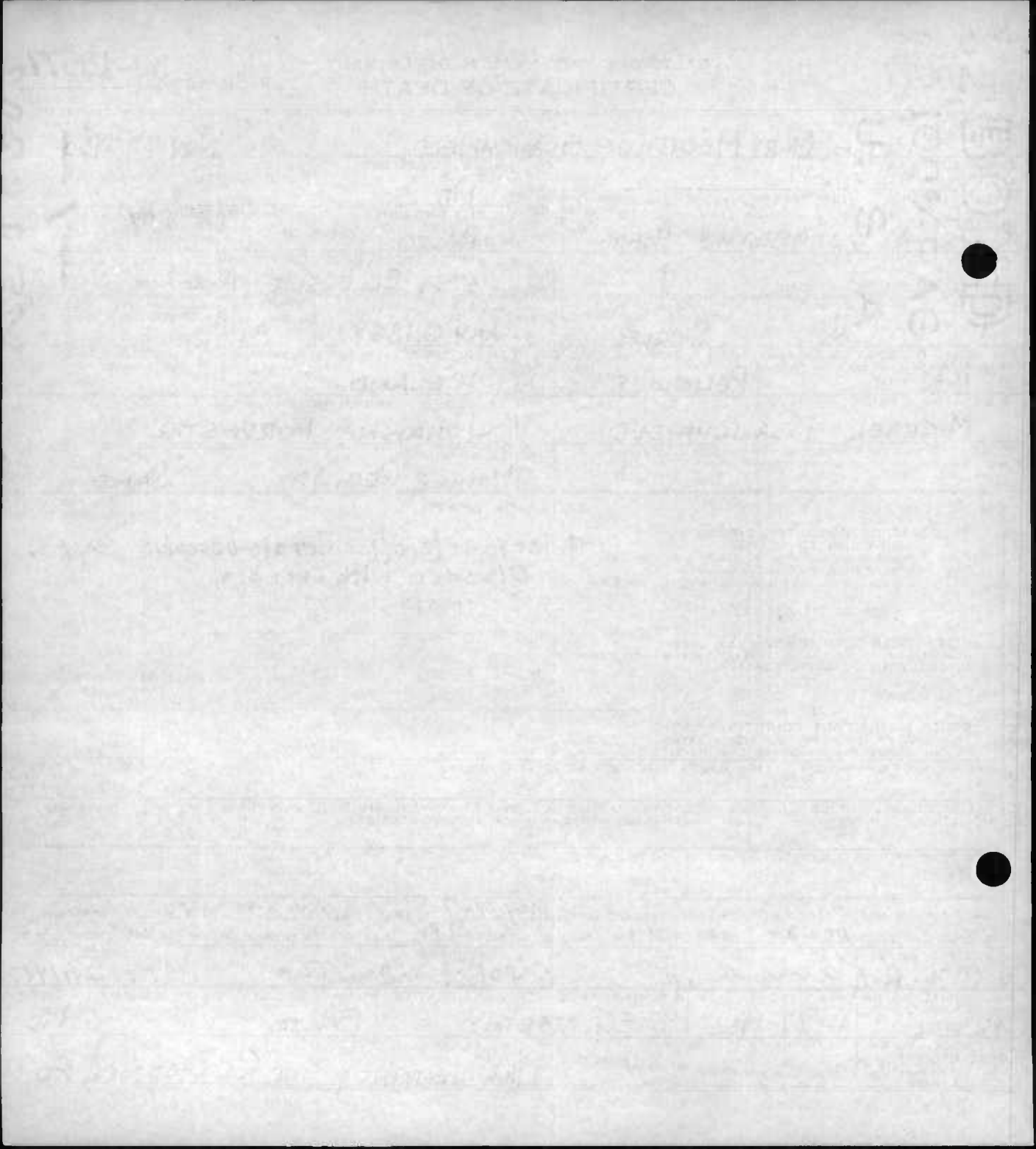
Registered No. 50-10077

452
50-10077
BIRTH NO.

1. NAME OF DECEASED (Type or Print) MOTHER MARY MECHTILDE BLANCHFIELD		2. DATE OF DEATH Nov. 23, 1950	
3. PLACE OF DEATH: a. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE MD. b. COUNTY BALTO	
b. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION 3725 ELLERSLIE AVE ST. ELIZABETHS HOME		c. CITY OR TOWN (If outside corporate limits, give RURAL and give township) BALTO	
c. Length of stay in Baltimore ? Yrs. ? Mos. ? Days ?		d. STREET ADDRESS (If rural, give location) 3725 ELLERSLIE AVE	
5. SEX F	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) SINGLE	8. DATE OF BIRTH JULY 6, 1869
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NUN		10b. KIND OF BUSINESS OR INDUSTRY RELIGIOUS	
13. FATHER'S NAME MICHAEL BLANCHFIELD		14. MOTHER'S MAIDEN NAME JOHANNA FORRESTAL	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT MOTHER REGINA		ADDRESS SAME	

18. <u>422.1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Cardio-Vascular Disease with Cerebral Sclerosis		INTERVAL BETWEEN ONSET AND DEATH
(A) DUE TO		
(B) DUE TO		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

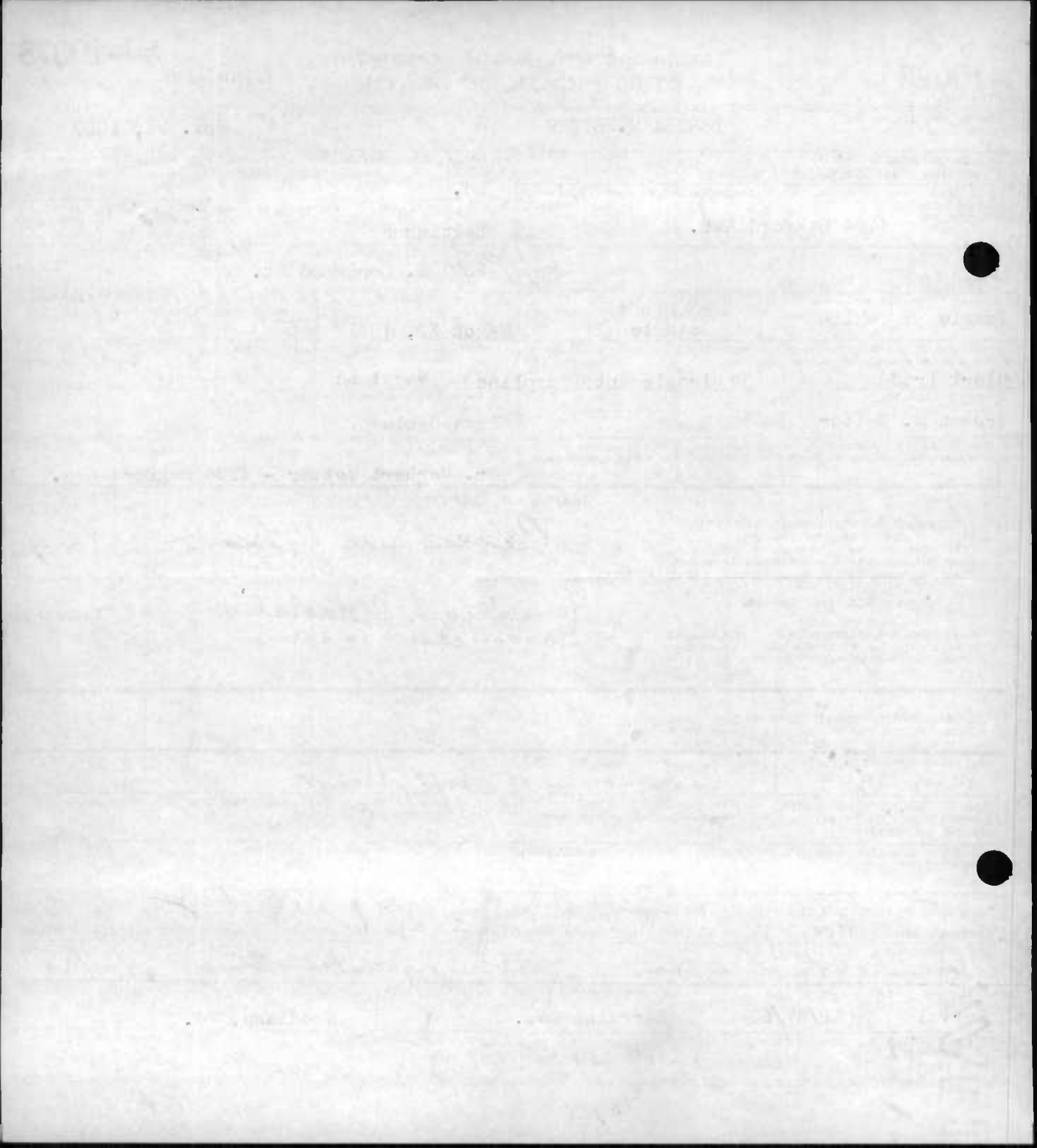
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21d. TIME (Month) (Day) (Year) (Hour) INJURY		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>May 1947</u> , 19 <u>50</u> , to <u>Nov. 23</u> , 19 <u>50</u> , that I last saw the deceased alive on <u>Nov. 22</u> , 19 <u>50</u> ; and that death occurred at <u>2 P.</u> m., from the causes and on the date stated above.					
23a. SIGNATURE <u>Wm. H. Kammer, Jr.</u>		23b. ADDRESS <u>501 Sheridan Ave.</u>		23c. DATE SIGNED <u>Nov. 25, 1950</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24b. DATE 11-27-1950		24c. NAME OF CEMETERY OR CREMATORY ST. ELIZABETHS	
24d. DATE RECEIVED BY LOCAL REGISTRAR NOV 25 1950		24e. REGISTRAR'S SIGNATURE <u>Wm. H. Kammer, Jr.</u>		24f. FUNERAL DIRECTOR H.W. JENKINS & SONS Co. 4905 YORK RD.	
24g. ADDRESS BALTO		24h. ADDRESS MD		24i. ADDRESS BALTO	



360
0-10078BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50-10078

1. NAME OF DECEASED (Type or Print)		BERTHA M. VETTER		2. DATE OF DEATH Nov. 24, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 4104 Oakford Ave.				C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore	
c. Length of stay in Baltimore Yrs. Mos. Days				D. STREET ADDRESS (If rural, give location) 2307 N. Longwood St.	
5. SEX female	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) single	8. DATE OF BIRTH March 30, 1891	9. AGE (in years last birthday) 59	If Under 1 Year Months: Days If Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk (rtd)		10B. KIND OF BUSINESS OR INDUSTRY Wholesale Auto Supplies		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Ernest H. Vetter			12. CITIZEN OF WHAT COUNTRY?		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Mr. Herbert Vetter - 4104 Oakford Ave.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 170x I CAUSE OF DEATH Carcinoma of Breast DUE TO Generalized Metastatic Carcinoma to S.S. II ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				INTERVAL BETWEEN ONSET AND DEATH 2 1/2 yrs. 6 mos.	
19A. DATE OF OPERATION May 1949		19B. MAJOR FINDINGS OF OPERATION Carcinoma of left breast		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		21B. PLACE OF INJURY (e.g., at or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Oct. 1950, to Nov. 24, 1950, that I last saw the deceased alive on Nov. 23, 1950, and that death occurred at 5:15 A.M., from the causes and on the date stated above.					
23A. SIGNATURE Dorothy Robinson		23B. ADDRESS M. D. 2835 Jaynes Falls Pkwy		23C. DATE SIGNED 11/25/50	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/27/50		24C. NAME OF CEMETERY OR CREMATORY Lorraine Cem.	
24D. LOCATION (City, town, or county) (State) Woodlawn, Md.		24E. NAME OF CEMETERY OR CREMATORY Lorraine Cem.		24F. LOCATION (City, town, or county) (State) Woodlawn, Md.	
DATE RECEIVED BY LOCAL REGISTRAR NOV 25 1950		REGISTRAR'S SIGNATURE William Williams, M.D.		25. FUNERAL DIRECTOR J. J. Scales & Son - Balto	
VS 150		49060		50 Md.	



500

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50-10079

BIRTH NO. 50-10079

1. NAME OF DECEASED
(Type or Print)

MICHAEL J. COHAN

2. DATE
OF
DEATH

Nov. 23, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR INSTITUTE 2922 Westwood Ave.4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Md.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
BaltimoreD. STREET ADDRESS (If rural, give location)
2922 Westwood Ave.

C. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

male

6. COLOR OR RACE

white

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

married

8. DATE OF BIRTH

April 27, 1891

9. AGE (In years
last birthday)

59

If Under 1 Year
Months: Days
If Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Shipper

10B. KIND OF BUSINESS OR
INDUSTRY

Cleaners

11. BIRTHPLACE (State or foreign country)

New York

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

- Cohan

14. MOTHER'S MAIDEN NAME

Esther

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknowns) (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.
072-01-7015

17. INFORMANT

ADDRESS

Mrs. Michael J. Cohan 2922 Westwood Ave.

18. 420.1

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) DUE TO

Coronary occlusion

INTERVAL BETWEEN
ONSET AND DEATH

3 days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

Coronary arteriosclerosis

10 years

(C)

II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH21B. PLACE OF INJURY (e.g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov. 20, 1950, to Nov. 23, 1950, that I last saw the
deceased alive on Nov. 23, 1950, and that death occurred at 6 A. m., from the causes and on the date stated above.

23A. SIGNATURE

Abraham B. Hurwitz

M. O.

23B. ADDRESS

3048 W. North Ave.

23C. DATE SIGNED

Nov. 24, 1950

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)
Burial

24B. DATE

11/25/50

24C. NAME OF CEMETERY OR CREMATORY

Woodlawn Cem.

24D. LOCATION (City, town, or county) (State)

Woodlawn, Md.

DATE RECEIVED BY
LOCAL REGISTRAR

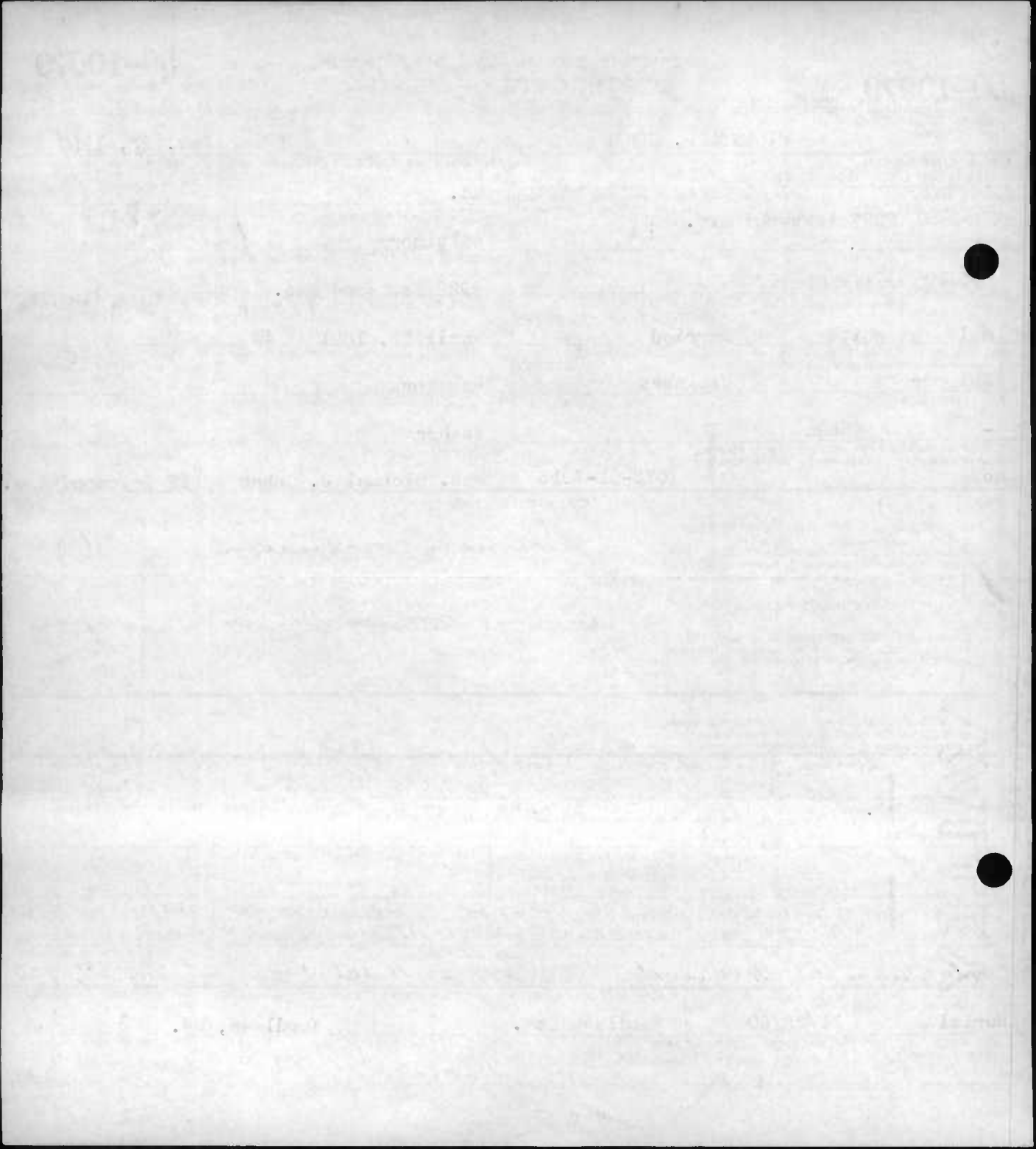
REGISTRAR'S SIGNATURE

John Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

J. F. Dickner & Sons - Balt. Md.



165
50-10080
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10080

Registered No.

1. NAME OF DECEASED (Type or Print) <i>George Hovermale</i>		2. DATE OF DEATH <i>Nov. 23, 1950</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md</i> B. COUNTY	
5. FULL NAME OF HOSPITAL OR INSTITUTION <i>JOHNS HOPKINS HOSPITAL</i>		C. CITY OR TOWN (If outside corporate limits write RURAL and give township) <i>Baltimore</i>	
6. Length of stay in Baltimore Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) <i>745 Edgewood St</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>married</i>	8. DATE OF BIRTH <i>5-16-05</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Truck Driver</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Transfer</i>	
13. FATHER'S NAME <i>George W. Hovermale</i>		14. MOTHER'S MAIDEN NAME <i>Bessie Grace Hovermale</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>JOHNS HOPKINS HOSPITAL</i>		ADDRESS	

18. <i>002X</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>PULMONARY TUBERCULOSIS</i>		INTERVAL BETWEEN ONSET AND DEATH <i>4 1/2 YRS</i>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION <i>11/27/50</i>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>10/27</i> , 19 <i>50</i> , to <i>11/23</i> , 19 <i>50</i> , that I last saw the deceased alive on <i>11/23</i> , 19 <i>50</i> , and that death occurred at <i>m.</i> , from the causes and on the date stated above.					
23A. SIGNATURE <i>Joseph Stokes III</i> M. D.		23B. ADDRESS <i>JOHNS HOPKINS HOSPITAL</i>		23C. DATE SIGNED <i>11-23-50</i>	

24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>11/27/50</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Woodlawn Cem.</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>	
DATE RECEIVED BY LOCAL REGISTRAR <i>NOV 25 1950</i>		REGISTRAR'S SIGNATURE <i>Wm. J. Lickner</i>		25. FUNERAL DIRECTOR <i>Wm. J. Lickner</i>		ADDRESS <i>Baltimore, Md.</i>	

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prohibition

THE UNIVERSITY OF TEXAS AT AUSTIN

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11-23-22

prohibition

260

50-10081

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50-10081

1. NAME OF DECEASED (Type or Print) <i>Annie S. Tucker</i> (Tucker)		2. DATE OF DEATH 11-24-50	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i>	
B. FULL NAME OF (If not in hospital or institution, give street address or location) <i>St. Agnes Hospital</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Catonsville</i>	
c. Length of stay in Baltimore Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) <i>41. Overbrook Road 5300</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>widow</i>	8. DATE OF BIRTH <i>July 5, 1866</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>at home</i>	9. AGE (in years last birthday) <i>84</i>
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Frederick Lindt</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>no</i>		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Mrs. Emerson Tucker - 41 Overbrook Rd.</i>		ADDRESS	

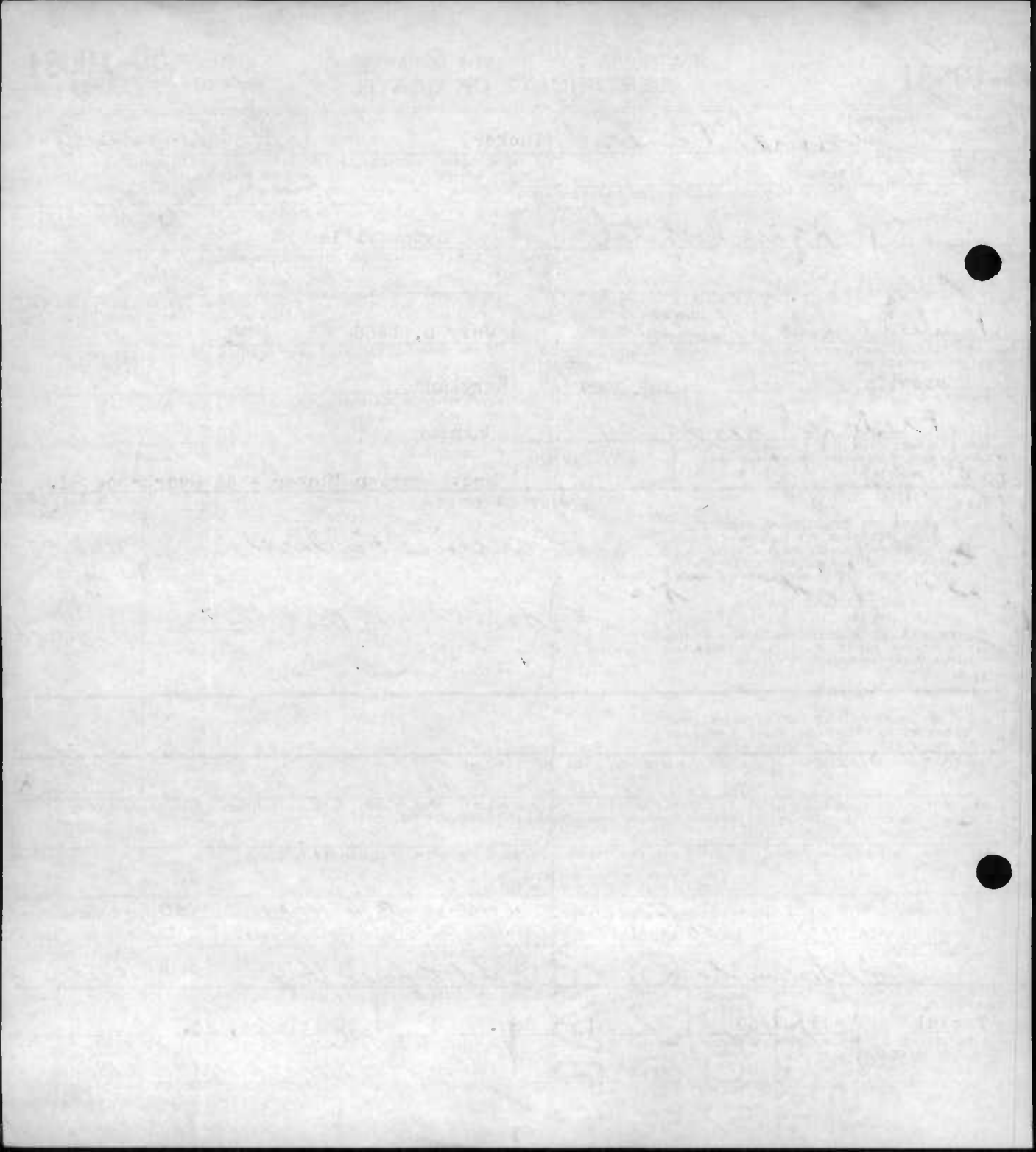
18. <i>490 X</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) DUE TO <i>Cardiac Failure</i>		INTERVAL BETWEEN ONSET AND DEATH <i>11-16-50</i> <i>6</i>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO <i>Serious & Bilateral</i> <i>Pneumonia</i>		<i>11-24-50</i>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME (Month) (Day) (Year) (Hour) INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from <i>11-16-50</i> , 19 <i>50</i> , to <i>11-24</i> , 19 <i>50</i> , that I last saw the deceased alive on <i>11-24</i> , 19 <i>50</i> , and that death occurred at <i>2:22</i> a.m., from the causes and on the date stated above.				
23A. SIGNATURE <i>A. Brown</i>		23B. ADDRESS <i>St Agnes Hosp</i>		23C. DATE SIGNED <i>11-24-50</i>

24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>11/27/50</i>	24C. NAME OF CEMETERY OR CREMATORY <i>Western Cem.</i>	24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>
DATE RECEIVED BY LOCAL REGISTRAR <i>NOV 25 1950</i>	REGISTRAR'S SIGNATURE <i>Wm. J. Pickner</i>	25. FUNERAL DIRECTOR <i>Wm. J. Pickner & Sons - Balt</i>	

108 Md.

MEDICAL CERTIFICATION



530
0-10082
BIRTH NO.BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50-10082

1. NAME OF DECEASED (Type or Print) <i>Ruby Snead</i>		2. DATE OF DEATH <i>11-18-50</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>12-05</i>	
5. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTE <i>454 E. Federal St</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore</i>	
6. Length of stay in Baltimore <i>22 yrs</i>		D. STREET ADDRESS (If rural, give location) <i>454 E. Federal St</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Colored</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Married</i>	8. DATE OF BIRTH <i>Aug 24 1927</i>
9. AGE (In years last birthday) <i>23</i>		10. Under 1 Year Months: Days: Under 24 Hours Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Penticoke Maryland</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Samuel G. Bass</i>		14. MOTHER'S MAIDEN NAME <i>Amanda Davis</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Agnes G. Cornish - 454 E. Federal St.</i>		ADDRESS	
18. <i>002X</i> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Far Advanced Pulmonary</i> DUE TO <i>Tuberculosis</i> INTERVAL BETWEEN ONSET AND DEATH			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO (C)			
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that I took charge of the remains described above, held an <i>Inspection</i> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .			
23A. SIGNATURE <i>William V. Smith</i>		23B. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> M.D. MEDICAL INVESTIGATOR <input type="checkbox"/>	
23C. DATE SIGNED <i>11-19-50</i>			
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Buried</i>		24B. DATE <i>11/25/50</i>	
24C. NAME OF CEMETERY OR CREMATORY <i>Mt. Auburn</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore</i>	
DATE RECEIVED BY LOCAL REGISTRAR <i>NOV 25 1950</i>		REGISTRAR'S SIGNATURE <i>Wm. A. Jackson</i>	
25. FUNERAL DIRECTOR <i>Wm. A. Jackson - 916 PENNA. AVE</i>		ADDRESS	

200

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10083

Registered No.

BIRTH NO.		1. NAME OF DECEASED (Type or Print) HAYMAN I. SACHS		2. DATE OF DEATH November 23, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY			
B. FULL NAME OF HOSPITAL OR INSTITUTION 3701 Nortonia Road Mount Nursing Home		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore			
c. Length of stay in Baltimore 55 yrs.		D. STREET ADDRESS (If rural, give location) 5700 Ranny Road			
5. SEX male	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH March 28, 1876	9. AGE (In years last birthday) 74	10. Under 1 Year Months: Days 11. Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Watches (R)		10B. KIND OF BUSINESS OR INDUSTRY Salesman		11. BIRTHPLACE (State or foreign country) Russia	
12. CITIZEN OF WHAT COUNTRY? USA.		13. FATHER'S NAME Saul Sachs		14. MOTHER'S MAIDEN NAME Etta Joseph	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Ida Sachs - 5700 Ranny Road	

18. **422.1**

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) **Anteriodiastolic CVD**

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) **Congestive Heart Failure**

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C) **Generalized Atherosclerosis
Benign Prostatic Hypertrophy - Semilit**

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

22. TIME (Month) (Day) (Year) (Hour) INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT ☐ WORK AT WORK ☐

22. I hereby certify that I attended the deceased from **June 1948** to **Nov 23, 1950**, that I last saw the deceased alive on **Nov 23, 1950**, and that death occurred at **3:10 P. m.**, from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

William C. Applegate

M. D.

2511 Reisterstown Rd**11/24/50**

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

Burial**11/26/50****Chizuk Amuno (Arlington)****Baltimore, Maryland**

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

NOV 25 1950**William C. Applegate****Sal. Levinson & Son, 1124-26 W. North Ave.**

<div style="font-size: 2em; font-weight: bold; margin-bottom: 5px;">500</div> <div style="font-size: 1.5em; font-weight: bold;">50-10084</div> <div style="font-size: 0.8em;">BIRTH NO.</div>		<div style="font-weight: bold;">BALTIMORE CITY HEALTH DEPARTMENT</div> <div style="font-weight: bold; font-size: 1.2em;">CERTIFICATE OF DEATH</div>		<div style="font-size: 1.5em; font-weight: bold;">50-10084</div> <div style="font-weight: bold;">Registered No.</div>	
1. NAME OF DECEASED (Type or Print) EVA COHEN			2. DATE OF DEATH November 23, 1950		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore		
B. FULL NAME OF (If not in hospital or institution, give street address or location) Sinai Hospital			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore		
C. Length of stay in Baltimore Yrs. Mos. Days 4811 Norwood Ave			D. STREET ADDRESS (If rural, give location)		
5. SEX female	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widow	8. DATE OF BIRTH January 10, 1895	9. AGE (In years last birthday) 55	10. Under 1 Year Months: Days: Under 24 Hours Hours: Min:
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10B. KIND OF BUSINESS OR INDUSTRY		
13. FATHER'S NAME Israel Crook			14. MOTHER'S MAIDEN NAME Yetta ?		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
17. INFORMANT Mrs Marcia Schwartz			ADDRESS 4811 Norwood Ave		
18. 551X and E945X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Cardiac failure DUE TO anoxia during anesthetic			INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO (C) OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION Nov. 23, 1950		19B. MAJOR FINDINGS OF OPERATION Preparation for appendectomy which was not done		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) hospital		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Sinai Hospital	
21D. TIME (Month) (Day) (Year) (Hour) November 23, 1950 7p.m.		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? Asphyxia during administration of anesthetic	
22. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input checked="" type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .					
23A. SIGNATURE RS Fisher			23B. CHIEF MEDICAL EXAMINER..... <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER..... <input type="checkbox"/> MEDICAL INVESTIGATOR..... <input type="checkbox"/> M.D. Nov. 24, 1950		
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE Nov 26, 1950		24C. NAME OF CEMETERY OR CREMATORY Aitz Chaim Cong Cemetery	
24D. LOCATION (City, town, or county) Washington Blvd		24E. FUNERAL DIRECTOR Sal Lewinsohn Ben		24F. ADDRESS 1126 W North ave	
DATE RECEIVED BY LOCAL REGISTRAR Nov 23 1950					
REGISTRAR'S SIGNATURE William M. Williams					
VS 151 N 998X					

BALTIMORE CITY HEALTH DEPARTMENT
 CERTIFICATE OF DEATH

*Cause for which operation
 was to have been performed*

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		COUNTRY OF BIRTH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH	

320

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

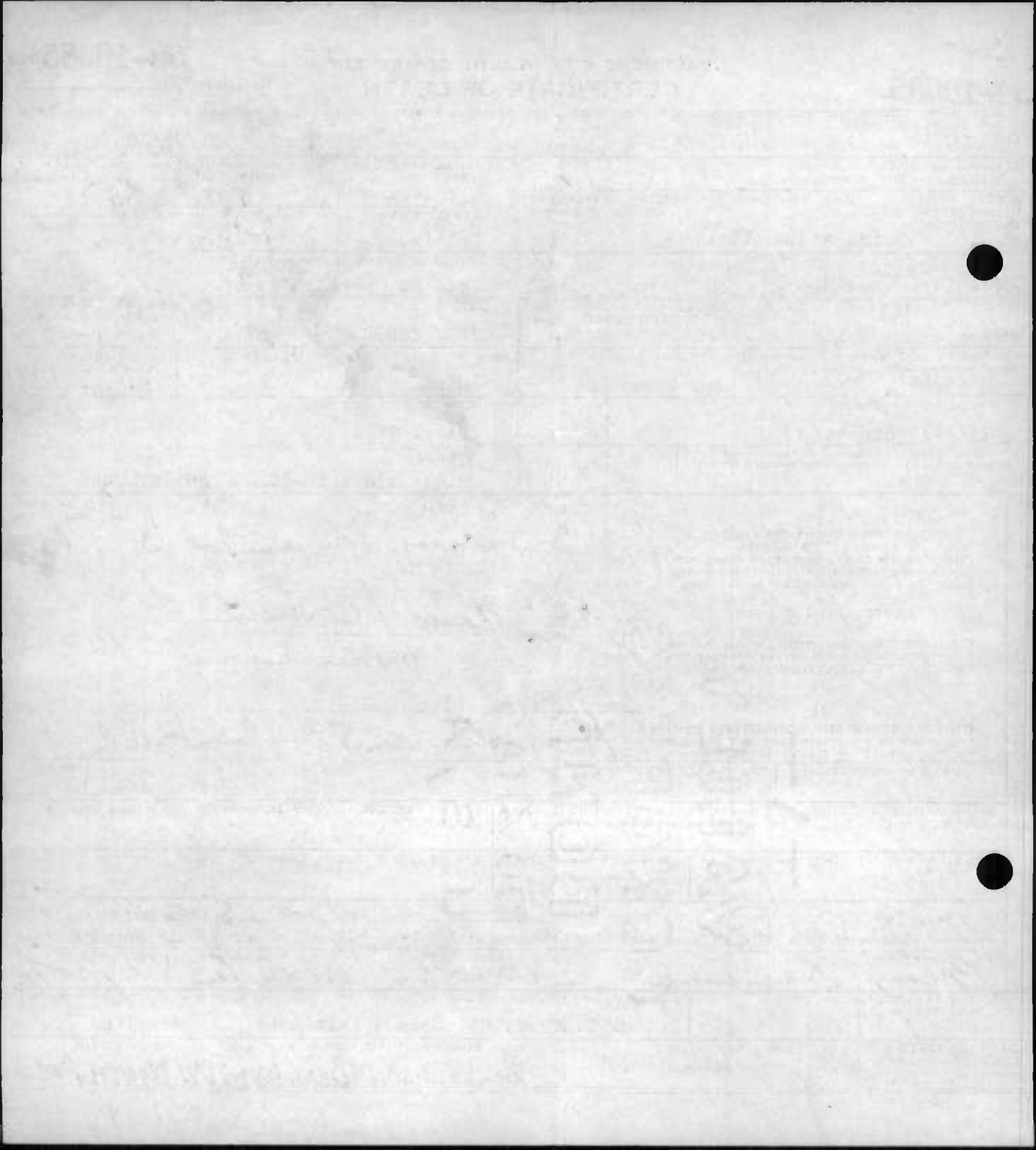
50-10085

Registered No.

50-10085

1. NAME OF DECEASED (Type or Print)		Goldie Katz		2. DATE OF DEATH		11/25/50	
3. PLACE OF DEATH: A. Baltimore City, Maryland				4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE Maryland B. COUNTY			
B. FULL NAME OF HOSPITAL OR INSTITUTION Lutheran Hospital				C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township) Baltimore			
c. Length of stay in Baltimore 30 Years				D. STREET ADDRESS (If rural, give location) 2844 W. Garrison Avenue			
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married M.	8. DATE OF BIRTH 12/3/1883	9. AGE (In years last birthday) 67	10. Under 1 Year Months Days	11. Under 24 Hours Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Russia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Israel Striner				14. MOTHER'S MAIDEN NAME Esther ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Mr. Melvin Katz-4021 Grantley Road			
18. 420.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CORONARY THROMBOSIS DUE TO 1st attack of Coronary Thrombosis ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. HYPERTENSION & DIABETES MELLITUS OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				CAUSE OF DEATH CORONARY THROMBOSIS INTERVAL BETWEEN ONSET AND DEATH 1 hour 10 weeks ?			
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Jan 1, 1950 to Nov 25, 1950, that I last saw the deceased alive on Nov 25, 1950, and that death occurred at 1:45 p. m., from the causes and on the date stated above.							
23A. SIGNATURE G. S. Samuelson				23B. ADDRESS 3128 W. North Ave.		23C. DATE SIGNED 11/25/50	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/26/50		24C. NAME OF CEMETERY OR CREMATORY Petach Tikvah, Rosedale		24D. LOCATION (City, town, or county) (State) Baltimore Maryland	
DATE RECEIVED BY LOCAL REGISTRAR NOV 25 1950		REGISTRAR'S SIGNATURE Huntington Williams, M.D.		25. FUNERAL DIRECTOR ADDRESS Sol Levinson & Bros. 1124-26 W. NORTH AVE.			

MEDICAL CERTIFICATION



500
50-10086
BIRTH NO.BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10086

Registered No.

1. NAME OF DECEASED (Type or Print) BERNARD KEENEY		2. DATE OF DEATH NOV 23, 1950	
3. PLACE OF DEATH: a. Baltimore City, Maryland OSL, 6		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 3-02	
b. FULL NAME OF HOSPITAL OR INSTITUTION JOHNS HOPKINS HOSPITAL		c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE	
c. Length of stay in Baltimore Yrs. Mos. Days		d. STREET ADDRESS (If rural, give location) 250 S. EDEN ST.	
5. SEX MALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH 3-21-94
9. AGE (in years last birthday) 56 YRS		10. Under 1 Year Months: Days	11. Under 24 Hours Hours: Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY CONST	
11. BIRTHPLACE (State or foreign country) MD (Granite)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Erna Keeneey		14. MOTHER'S MAIDEN NAME Rebecca Young	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT JOHNS HOPKINS HOSPITAL		ADDRESS	
18. 331X CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Cerebral vascular accident (A) DUE TO INTERVAL BETWEEN ONSET AND DEATH ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO (C) II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19a. DATE OF OPERATION 11-23-50		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21d. TIME (Month) (Day) (Year) (Hour) INJURY	
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 11-22-50 1950, to 11-23-50 1950, that I last saw the deceased alive on 11-23-50 1950, and that death occurred at 1:50 a.m., from the causes and on the date stated above.			
23a. SIGNATURE Samuel A. Bowdler, M.D.		23b. ADDRESS JOHNS HOPKINS HOSPITAL	
23c. DATE SIGNED 11/23/50			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 11/25/50	
24c. NAME OF CEMETERY OR CREMATORY Quilford M.C. Ch.		24d. LOCATION (City, town, or county) (State) Quilford Md	
DATE RECEIVED BY LOCAL REGISTRAR NOV 25 1950		REGISTRAR'S SIGNATURE Huntington Williams	
25. FUNERAL DIRECTOR Willard Funeral Home		ADDRESS Chilmark St	

564 24

083a

10-1-1988

10-1-1988

10-1-1988

Central register account

10-1-1988

10-1-1988

10-1-1988

10-1-1988

10-1-1988

10-1-1988

D-516
50-10087Baltimore
BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

50-10087

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

ISRAEL DINABURG

2. DATE
OF
DEATH

11/25/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF
HOSPITAL OR
INSTITUTION
(If not in hospital or institution, give street address or location)

Susan

4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)

A. STATE

B. COUNTY

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

Baltimore 27-12
5019 Senmore Ave

Length of stay in Baltimore

45

Yrs.
Mos.
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

75

9. AGE (In years)

75

If Under 1 Year

Months: Days

If Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during last of working life, even if retired)

Retired

10B. KIND OF BUSINESS OR INDUSTRY

Tailor

11. BIRTH PLACE (State or foreign country)

Russia

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Lazer

14. MOTHER'S MAIDEN NAME

Not Known

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Sarah Dinaburg - Same

18. 422.1

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)

(A)

Cerebrovascular Accident

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

Arteriosclerotic Vascular Disease

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT WORK ☐NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov 23, 1950, to Nov 25, 1950, that I last saw the deceased alive on Nov 25, 1950, and that death occurred at 12 30 p.m., from the causes and on the date stated above.

23A. SIGNATURE

Karl Schubert

M. D.

23B. ADDRESS

5101 S. P. Baltimore

23C. DATE SIGNED

Nov 25 50

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

11-26-50

24C. NAME OF CEMETERY OR CREMATORY

Hebrew Mt Carmel

24D. LOCATION (City, town, or county) (State)

Balt, Md

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

VS 150

NOV 26 1950

937

STATE OF NEW YORK
CERTIFICATE OF DEATH

72

G-350
50-10088BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10088

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

FANNIE GOIEN

2. DATE
OF
DEATH

11-24-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF
HOSPITAL OR
INSTITUTION

5012 Palmer Ave

C. Length of stay in Baltimore

Life

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Md

B. COUNTY

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

5012 Palmer Ave

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

Married

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

13. FATHER'S NAME

Samuel

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

William Goden - Bane

18. 443X

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary edema

DUE TO

INTERVAL BETWEEN
ONSET AND DEATH

3 hrs.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) Hypertensive Cardiovascular Dis.

DUE TO

(C) Hypertension and Arteriosclerosis

10 yrs?

20 yrs?

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Pneumectomy, ef. for tuberculosis

17 yrs.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4pm - 11/24/50 to 6pm - 11/24/50, that I last saw the deceased alive on 11/24/50 and that death occurred at 6:15 PM, from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

NOV 26 1950

JACK LEWIS 2100 CECIL RD

93D

1892-93

1892-93

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B-451
50-10089BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10089

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

V9608 BLUMBERG

2. DATE
OF
DEATH

11/25/1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF
HOSPITAL OR
INSTITUTION

3901 NORFOLK AVE

4. USUAL RESIDENCE (Where deceased lived. If institution: residence
before admission)

A. STATE

MARYLAND

B. COUNTY

C. CITY OR TOWN

BALTO.

(If outside corporate limits, write RURAL and give
township)

15-09

D. STREET ADDRESS (If rural, give location)

3901 NORFOLK AVE

c. Length of stay in Baltimore

VS

Yrs.
Mos.
Days

5. SEX

MALE

6. COLOR OR RACE

WHITE

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

MARRIED

8. DATE OF BIRTH

9. AGE (in years
last birthday)

76

10 Under 1 Year
Months: Days11 Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

RETIRED

10B. KIND OF BUSINESS OR
INDUSTRY

TAILOR

11. BIRTHPLACE (State or foreign country)

LITH.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

SAMUEL

14. MOTHER'S MAIDEN NAME

SHANG

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

MARY BLUMBERG- 3901 NORFOLK AVE

18. 422.1

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) Arteriosclerotic Cardio - 7mo

DUE TO vascular Disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST,

(B)

DUE TO

(C)

INTERVAL BETWEEN
ONSET AND DEATH

7mo

II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

m. WHILE AT ☐ NOT WHILE
WORK AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11/24, 1950, to 11/25, 1950, that I last saw the
deceased alive on 11/25, 1950, and that death occurred at 4⁰⁰ P.m., from the causes and on the date stated above.

23A. SIGNATURE

Albert Subintolay

23B. ADDRESS

M. D. 7524 Seven Mile Lane

23C. DATE SIGNED

11/25/50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

BURIAL

24B. DATE

11/26/1950

24C. NAME OF CEMETERY OR CREMATORY

BETH TFILOH

24D. LOCATION (City, town, or county)

BALTO.

(State)

MD

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

The Hon. William H. Williams

25. FUNERAL DIRECTOR

ADDRESS

JACK LEWIS INC- 2100 FORTA W PL

VS 150

937

MEDICAL CERTIFICATION

B-621
50-10090

50-10090

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <i>Benjamin Berzofsky (BERZOFSKY)</i>		2. DATE OF DEATH <i>24 Nov '50</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY	
B. FULL NAME OF (If not in hospital or institution, give street address or location) <i>Senar</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Balto.</i>	
C. Length of stay in Baltimore <i>38</i> Yrs. <i>None</i> Days		D. STREET ADDRESS (If rural, give location) <i>4012 Pinkney Road</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>M</i>	8. DATE OF BIRTH <i>4-22-1896</i>
9. AGE (In years last birthday) <i>54</i>		10. AGE (In years last birthday) <i>54</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Merchant</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Furniture</i>	
11. BIRTHPLACE (State or foreign country) <i>Russia</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Not known</i>		14. MOTHER'S MAIDEN NAME <i>Tuba</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>no</i>		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Rebecca Berzofsky - Son</i>		ADDRESS	

18. <i>420.1</i>	CAUSE OF DEATH	INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) <i>Acute Myocardial Infarction</i>	
ANTECEDENT CAUSES	(B)	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(C)	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION <i>0</i>	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from <i>23 Nov 1950</i> , to <i>24 Nov 1950</i> , that I last saw the deceased alive on <i>24 Nov 1950</i> , and that death occurred at <i>6:25 P.M.</i> , from the causes and on the date stated above.		
23A. SIGNATURE <i>George H. Greenstein</i> M. O.	23B. ADDRESS <i>Sinai Hospital</i>	23C. DATE SIGNED <i>24 Nov 50</i>
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>11/26/50</i>	24C. NAME OF CEMETERY OR CREMATORY <i>Arlington</i>
24D. LOCATION (City, town, or county) <i>Balto</i>	(State) <i>Md</i>	
DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR <i>Jack Lewis Inc</i> ADDRESS <i>2100 Eutaw Pl</i>

02-11-1981

CERTIFICATE OF DEATH

STATE OF NEW YORK

02-11-1981



M-440
50-10091BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50-10091
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

EMMA MALLALIEU

2. DATE
OF
DEATH

Nov. 25, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION

308 W. Lorraine Ave.

Yrs.
Mos.
Days

C. Length of stay in Baltimore

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE

Maryland

B. COUNTY (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

308 W. Lorraine Ave.

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Widow

8. DATE OF BIRTH

Nov. 22, 1959

9. AGE (In years,
last birthday)

91

If Under 1 Year
Months: Days: Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Car Cleaner, retired

10B. KIND OF BUSINESS OR
INDUSTRY

P.R.R.

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Joseph Tucker

14. MOTHER'S MAIDEN NAME

Marie Bishop

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs Genevieve Strobel, 308 W. Lorraine Ave

18. 410 X I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A)

DUE TO

Chronic Valvular Heart Disease 1940
(cardiac insufficiency)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

Chr. Intestinal Nephritis 1940

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22. I hereby certify that I attended the deceased from June 15, 1950, to Nov. 25, 1950, that I last saw the deceased alive on Nov 24, 1950, and that death occurred at 7:15 A. M., from the causes and on the date stated above.

22A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

M. D.

3602 Liberty Heights Ar.

11-25-50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

11/27/50

24C. NAME OF CEMETERY OR CREMATORY

Baltimore

24D. LOCATION (City, town, or county) (State)

Baltimore, Md.

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

NOV 25 1950

131a

100-10001

100-10001

WALLER



220
50-10092BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50-10092
Registered No.

BIRTH NO.		1. NAME OF DECEASED (Type or Print) AGATA WASZAK		2. DATE OF DEATH November 23, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore			
B. FULL NAME OF HOSPITAL OR INSTITUTION 314 S. Wolfe Street		C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township) Baltimore			
c. Length of stay in Baltimore 48 years		D. STREET ADDRESS (If rural, give location) 314 S. Wolfe Street			
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed	B. DATE OF BIRTH March 3, 1882		9. AGE (In years last birthday) 68
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Household worker		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Kendzierz, Poland	
13. FATHER'S NAME Adam Sidor		14. MOTHER'S MAIDEN NAME Sophia Wojciechowska		12. CITIZEN OF WHAT COUNTRY? USA	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Mrs. Josephine Borowski, 314 S. Wolfe Street	
18. 422.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Broncho pneumonia ANTECEDENT CAUSES Chronic Myocarditis DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. General Arterio Sclerosis II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Nov 9 5 49 , 19 50 to Nov 23 50 , that I last saw the deceased alive on Nov 23, 1950 and that death occurred at 2:15 p.m. , from the causes and on the date stated above.					
23A. SIGNATURE Robert F. Solomon		23B. ADDRESS 129 S. Bway		23C. DATE SIGNED 11/24/50	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/27/50		24C. NAME OF CEMETERY OR CREMATORY St. Stanislaus	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25. FUNERAL DIRECTOR ADDRESS M. F. Sadowski & Sons, 1808 Eastern Avenue			

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CERTIFICATE CORRECTED 11-30-50

BALTIMORE CITY HEALTH DEPARTMENT

50-10093

CERTIFICATE OF DEATH

Registered No. 50-10093

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

MARY. LOEHR.

2. DATE
OF
DEATH

NOV. 23. 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland Balto City.

B. FULL NAME OF
HOSPITAL OR
INSTITUTION (If not in hospital or institution, give street address or location)

338 S. East ave

4. USUAL RESIDENCE (Where deceased lived, If institution: residence
A. STATE B. COUNTY before admission)

Md.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

338 S. East ave

c. Length of stay in Baltimore

Life

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH 1865 9. AGE (In years last birthday) 85. 11. Under 1 Year Months: Days 11. Under 24 Hours Hours: Min.

Nov. 23. 1865

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Huss. maker

10B. KIND OF BUSINESS OR INDUSTRY

seamstress

13. FATHER'S NAME

MICHAEL LOEHR.

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A

14. MOTHER'S M maiden NAME

ROSALIA. Schweitzer

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

no

no

16. SOCIAL SECURITY NO.

NONE

17. INFORMANT

ADDRESS

Maria Heemeter 338 S. East ave

18. 420.1

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Atherosclerosis C.V. Disease

DUE TO

9-1-50

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, (A) STATING THE UNDERLYING CONDITION LAST.

(B) Chl. Myocarditis

DUE TO

9-1-50

Acute Coronary Occlusion

11-23-50

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

none

19B. MAJOR FINDINGS OF OPERATION

none

20. AUTOPSY?

YES ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

none

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

none

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

none

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

none

21E. INJURY OCCURRED

WHILE AT WORK ☒ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

none

22. I hereby certify that I attended the deceased from 9-1-50, 19, to 11-23, 1950, that I last saw the deceased alive on 11-22, 1950, and that death occurred at 7:20 p.m., from the causes and on the date stated above.

23A. SIGNATURE

Erich Schumacher

M. D.

23B. ADDRESS

842 E. East Ave

23C. DATE SIGNED

11-25-50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

Nov. 27. 1950

24C. NAME OF CEMETERY OR CREMATORY

Holy Redeemer

24D. LOCATION (City, town, or county)

Belair Road

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

F. J. Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

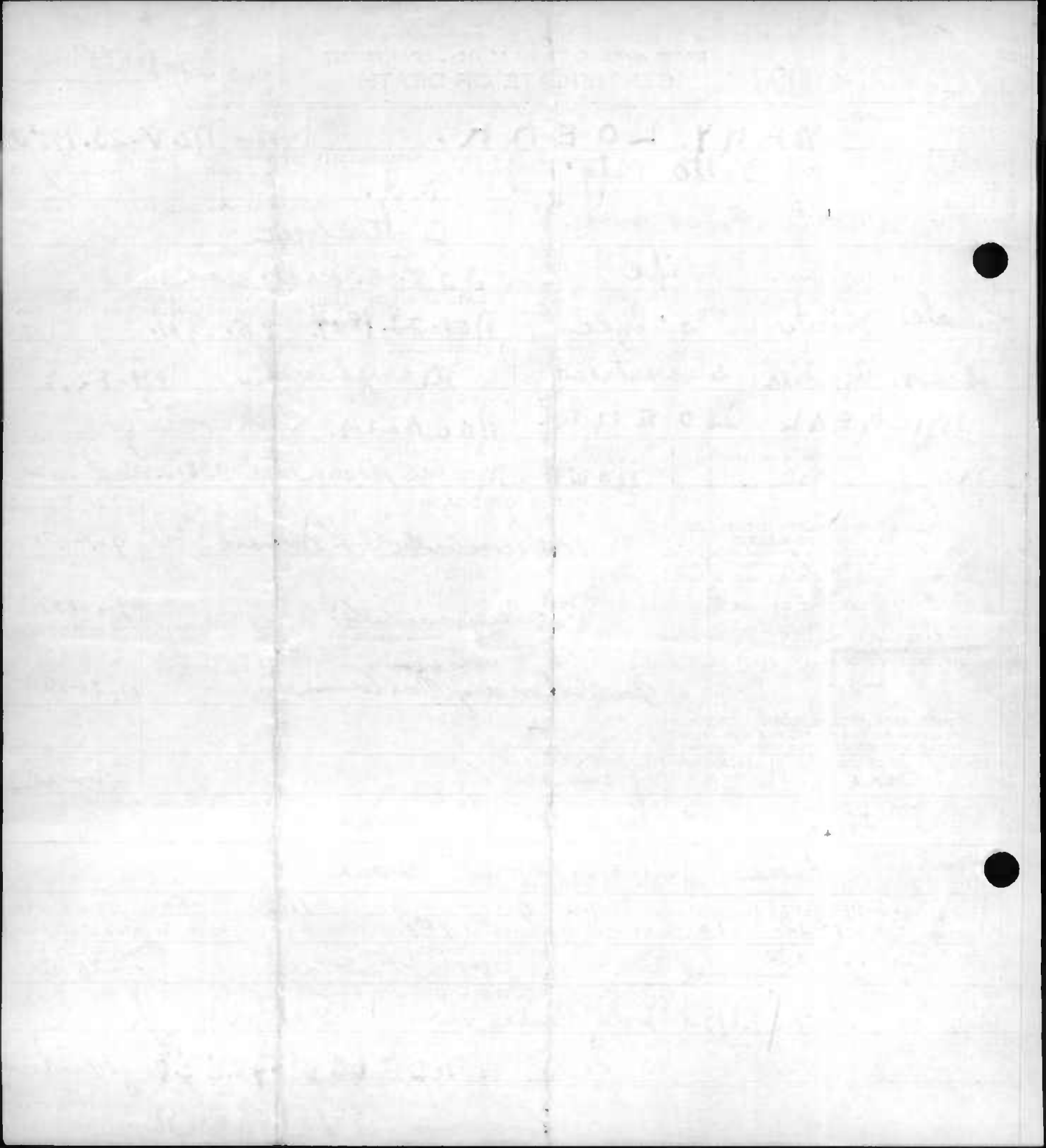
WENDELL J. PIPPERL 312 Highland Ave

NOV 26 1950

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MEDICAL CERTIFICATION



00
0-10094

Lackey
BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10094

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <i>Edgill Lackey</i>		2. DATE OF DEATH <i>November 26, 1950</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Pa.</i> B. COUNTY <i>York</i>	
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>JOHNS HOPKINS HOSPITAL</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>New Freedom</i>	
C. Length of stay in Baltimore <i>2 days</i>		D. STREET ADDRESS (If rural, give location)	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>married</i>	8. DATE OF BIRTH <i>4-6-23</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (in years last birthday) <i>27</i>
13. FATHER'S NAME <i>Clyde Ferguson</i>		11. BIRTHPLACE (State or foreign country) <i>New Freedom, Pa.</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>No</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
16. SOCIAL SECURITY NO.		14. MOTHER'S MAIDEN NAME <i>Rosalie Cook</i>	
17. INFORMANT <i>JOHNS HOPKINS HOSPITAL</i>		ADDRESS	

1B. <i>395X</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	CAUSE OF DEATH (A) <i>Direct cause unknown</i>	INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B) <i>Had Menier's Disease</i>	<i>29 yrs.</i>
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION <i>Nov 24, 1950</i>	19B. MAJOR FINDINGS OF OPERATION <i>No abnormalities - Section VIIIth N Rt.</i>	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from <i>11-21</i> , 1950, to <i>11-26</i> , 1950, that I last saw the deceased alive on <i>11-26</i> , 1950, and that death occurred at <i>3:30 P.m.</i> , from the causes and on the date stated above.		
23A. SIGNATURE <i>George S. Cullbreth</i>	23B. ADDRESS <i>JOHNS HOPKINS HOSPITAL</i>	23C. DATE SIGNED <i>Nov 26, 1950</i>

24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>Nov. 29, 1950</i>	24C. NAME OF CEMETERY OR CREMATORY <i>New Freedom.</i>	24D. LOCATION (City, town, or county) (State) <i>New Freedom, York Co., Pa.</i>
DATE RECEIVED BY LOCAL REGISTRAR <i>NOV 27 1950</i>	REGISTRAR'S SIGNATURE <i>William J. Williams, M.D.</i>	25. FUNERAL DIRECTOR <i>J. Jacob Vintenstein, New Freedom,</i>	

536
50-10095BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50-10095

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Marcella Mollie Andrzejewski-Andrews. <i>MOLLY ANDREWS</i>			2. DATE OF DEATH 11/25/50		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence A. STATE Maryland. B. COUNTY before admission)		
B. FULL NAME OF (If not in hospital or institution, give street address or HOSPITAL OR location) INSTITUTION SOUTH BALTO. GENERAL HOSPITAL			C. CITY OR TOWN (If outside corporate limits, write full name and give township) Baltimore-22		
c. Length of stay in Baltimore Yrs. Mos. Days			D. STREET ADDRESS (If rural, give location) 6706 Danville Avenue		
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH April 3, 1887	9. AGE (In years last birthday) 63	10. Under 1 Year Months: Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			11. BIRTHPLACE (State or foreign country) Chicago, Ill.		
10B. KIND OF BUSINESS OR INDUSTRY			12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME Wojciech George Sosnowski			14. MOTHER'S MAIDEN NAME Anna (Unknown)		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. 212-03-2101		
17. INFORMANT Joseph Andrzejewski Andrews 6706 Danville Ave					

18. 124X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CARCINOMA OF UTERUS DUE TO INTERVAL BETWEEN ONSET AND DEATH	CAUSE OF DEATH CARCINOMA OF UTERUS
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO (C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. HEMORRHAGE INTO ADRENALS	

19A. DATE OF OPERATION 10/25/50	19B. MAJOR FINDINGS OF OPERATION PELVIC INFLAMMATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **10/25**, 19**50**, to **11/25**, 19**50**, that I last saw the deceased alive on **11/25**, 19**50**, and that death occurred at **1 P** m., from the causes and on the date stated above.

23A. SIGNATURE William B. Croopa Jr.	23B. ADDRESS South Balto. General Hosp	23C. DATE SIGNED 11/25/50
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial	24B. DATE Nov. 29, 1950	24C. NAME OF CEMETERY OR CREMATORY St. Stanislaus
24D. LOCATION (City, town, or county) Baltimore, Md.		(State)

DATE RECEIVED BY LOCAL REGISTRAR NOV 27 1950	REGISTRAR'S SIGNATURE George A. Weber	25. FUNERAL DIRECTOR George A. Weber - 7058. Ann St.	ADDRESS per J. Weber
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BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10096

Registered No.

50-10096

1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH	
Joseph E. Bell		Nov. 23-1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE Md B. COUNTY Baltimore	
B. FULL NAME OF HOSPITAL OR INSTITUTION 929 N. Eden St		C. CITY OR TOWN (If outside corporate limits, write R.U.P.L. and give township) Baltimore	
c. Length of stay in Baltimore 35 yrs.		D. STREET ADDRESS (If rural, give location) 929 N. Eden St	
5. SEX M	6. COLOR OR RACE C	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) M.	8. DATE OF BIRTH Dec. 28-1893
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Porter		10B. KIND OF BUSINESS OR INDUSTRY W.F.B.R. - Radio	9. AGE (In years last birthday) 56
11. BIRTHPLACE (State or foreign country) Charles Co. Md.		12. CITIZEN OF WHAT COUNTRY? Unknown	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. Mae Bell-929 N. Eden St	
17. INFORMANT Mae Bell-929 N. Eden St		ADDRESS	
18. 442 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) hypertensive cardio-renal disease		INTERVAL BETWEEN ONSET AND DEATH unk.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (A) DUE TO (B) DUE TO (C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION O		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE <input type="checkbox"/> WORK AT WORK	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 11/13, 1950 to 11/23, 1950 and that death occurred at 11:25 AM from the causes and on the date stated above.			
23A. SIGNATURE [Signature]		23B. ADDRESS LAST MADISON ST. BALTIMORE	
23C. DATE SIGNED 11-24-50			
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE Nov. 27-1950	
24C. NAME OF CEMETERY OR CREMATORY Mt. Calvary		24D. LOCATION (City, town, or county) A.A. Co. Md.	
25. FUNERAL DIRECTOR Mamie W. Wright-721 Rossmore		ADDRESS	
DATE RECEIVED BY LOCAL REGISTRAR NOV 27 1950		REGISTRAR'S SIGNATURE [Signature]	

VS 150

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MEDICAL CERTIFICATION

10-10-51

WALTER
KING
JAMES

10-10-51

WALTER
KING
JAMES

10-10-51

WALTER
KING
JAMES

10-10-51

WALTER
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JAMES

WALTER
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JAMES

10-10-51

WALTER
KING
JAMES

10-10-51

WALTER
KING
JAMES

10-10-51

WALTER
KING
JAMES

430

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10097

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

DAVID PLATT

2. DATE
OF
DEATH

11-26-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, If institution; residence

A. STATE

B. COUNTY

before admission)

B. FULL NAME OF (If not in hospital or institution, give street address or
HOSPITAL OR location)
INSTITUTION

Levendale

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore 27-15

D. STREET ADDRESS (If rural, give location)

Levendale

c. Length of stay in Baltimore

43

Yrs.
Mos.
Days

5. SEX

male

6. COLOR OR RACE

white

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

widowed

8. DATE OF BIRTH

9. AGE (In years

last birthday)

If Under 1 Year

Months: Days

If Under 24 Hours

Hours: Min.

88

10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Retired

10B. KIND OF BUSINESS OR
INDUSTRY

Dairy

11. BIRTHPLACE (State or foreign country)

Lith

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Toskum

14. MOTHER'S MAIDEN NAME

Dora

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Nathan Platt - 3910 Fernhill Av

18. 332X

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) Cerebral thrombosis
DUE TO

2 days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) arteriosclerosis
DUE TO

years

(C)

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

Cholecystectomy & cholangitis

3 weeks

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH21B. PLACE OF INJURY (e.g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE
WORK AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 10th 1943, to 11-26-50, that I last saw the
deceased alive on 11-26, 1950, and that death occurred at 10³⁰ a.m., from the causes and on the date stated above.

23A. SIGNATURE

Henry Nagel

M. D.

23B. ADDRESS

Levendale Home

23C. DATE SIGNED

11-26-50

24. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

11-27-50

24C. NAME OF CEMETERY OR CREMATORY

United Hebrew

24D. LOCATION (City, town, or county) (State)

Baltimore, Md

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

William Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

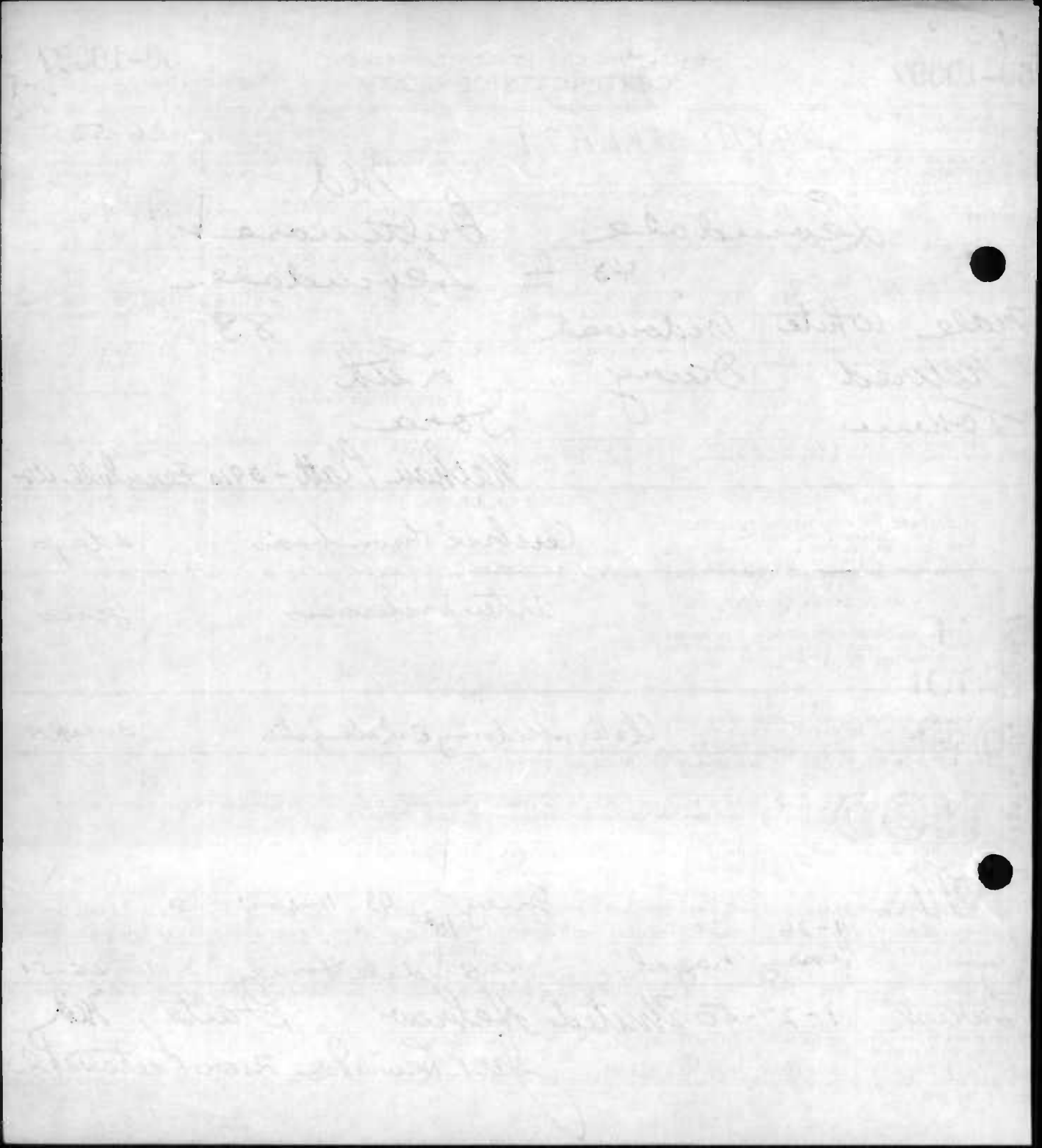
Jack Lewis 2100 Canton Pl

NOV 27 1950

VS 150

127a

MEDICAL CERTIFICATION



526
50-10098

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50-10098

BIRTH NO.		1. NAME OF DECEASED (Type or Print) WOLF SINGER		2. DATE OF DEATH 11-26-50	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE md B. COUNTY			
B. FULL NAME OF HOSPITAL OR INSTITUTION Levindale		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 17-15			
C. Length of stay in Baltimore 50 Yrs. Mo. Days		D. STREET ADDRESS (If rural, give location) Levindale			
5. SEX male	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed	B. DATE OF BIRTH 07-1	9. AGE (in years, months, days) 07-1	11. BIRTH PLACE (State or foreign country) Russia
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired		10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Isaac		14. MOTHER'S MAIDEN NAME Faga		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT Benjamin Singer - 1219 Hanover St		ADDRESS	
18. 332X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Cerebral thrombosis DUE TO Arteriosclerosis DUE TO Antecedent causes DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH Cerebral thrombosis Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 6 day years	
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from October , 19 40 , to 11-26 , 19 50 , that I last saw the deceased alive on 11-26 , 19 50 , and that death occurred at 7 a m., from the causes and on the date stated above.					
23A. SIGNATURE Henry Nagel		23B. ADDRESS Levindale Home		23C. DATE SIGNED 11-26-50	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-27-50		24C. NAME OF CEMETERY OR CREMATORY United Hebrew	
24D. LOCATION (City, town, or county) (State) Balto Md		24E. FUNERAL DIRECTOR Jack Lewin		24F. ADDRESS 2100 Eutan Pl	
DATE RECEIVED BY LOCAL REGISTRAR NOV 27 1950		REGISTRAR'S SIGNATURE William M. ...		VS 150	

MEDICAL CERTIFICATION

0836

**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

Registered No. **50-10099**

50-10099

1. NAME OF DECEASED (Type or Print) SAMUEL SCHERR			2. DATE OF DEATH 11-26-50		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY		
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTE Sinai Hosp of Baltimore			C. CITY OR TOWN (If outside corporate limits, write R.D. No. and give township) Baltimore 27-16		
c. Length of stay in Baltimore 36 Yrs. Months Days			D. STREET ADDRESS (If rural, give location) 3114 Sumter Ave		
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH		9. AGE (In years last birthday) 68
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tailor		10B. KIND OF BUSINESS OR INDUSTRY mens clothing		11. BIRTHPLACE (State or foreign country) (M) Russia	
13. FATHER'S NAME Not Known			14. MOTHER'S MAIDEN NAME Not Known		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Michael Scherr - Son	
				ADDRESS	

MEDICAL CERTIFICATION	18. 153X I		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH
	DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) Intestinal obstruction		
	ANTECEDENT CAUSES		(B) Carcinoma of Sigmoid		
	DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(C)		
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION Nov 13, 1950		19B. MAJOR FINDINGS OF OPERATION Carcinoma of Sigmoid		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from **11-13-50**, 19**50**, to **11-26**, 19**50**, that I last saw the deceased alive on **11-26**, 19**50**, and that death occurred at **3:40 A.m.**, from the causes and on the date stated above.

22A. SIGNATURE Joseph Louis Feingold		22B. ADDRESS Sinai Hospital		22C. DATE SIGNED 11-26-50	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-27-50		24C. NAME OF CEMETERY OR CREMATORY Mt Carmel	
				24D. LOCATION (City, town, or county) (State) Balto Md	
DATE RECEIVED BY LOCAL REGISTRAR NOV 27 1950		REGISTRAR'S SIGNATURE Washington Williams, MD		25. FUNERAL DIRECTOR Jack Lewis	
				ADDRESS 3100 Easton Pl	

UNITED STATES GOVERNMENT
DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY
WASHINGTON, D. C.

1915-10-15

1915-10-15

TO THE DIRECTOR, BUREAU OF PLANT INDUSTRY, U. S. DEPT. OF AGRICULTURE, WASHINGTON, D. C.

FROM THE DIRECTOR, BUREAU OF PLANT INDUSTRY, U. S. DEPT. OF AGRICULTURE, WASHINGTON, D. C.

SUBJECT: [Illegible]

RE: [Illegible]

DATE: [Illegible]

BY: [Illegible]

FOR: [Illegible]

BY: [Illegible]

FOR: [Illegible]

BY: [Illegible]

FOR: [Illegible]

BY: [Illegible]

FOR: [Illegible]

BY: [Illegible]

FOR: [Illegible]

BY: [Illegible]

FOR: [Illegible]

BY: [Illegible]

FOR: [Illegible]

BY: [Illegible]

FOR: [Illegible]

BY: [Illegible]

625

REA-143145

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10100

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Betty Ann Harrison

2. DATE
OF
DEATH

11-7-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence
before admission)A. STATE
Maryland

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or
location)
HOSPITAL OR INSTITUTIONBaltimore City Hospitals
4940 Eastern AvenueC. CITY OR TOWN (If outside corporate limits, write RURAL and give
township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1521 W. Fayette Street

c. Length of stay in Baltimore

Life

Yrs.
Mos.
Days

5. SEX

Female

6. COLOR OR RACE

Negro

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

Aug. 23, 1950

9. AGE (In years
last birthday)10. Under 1 Year
Months: Days11. Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Charles Harrison

14. MOTHER'S MAIDEN NAME

Estelle Flowers

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Records: B. C. H. 4940 Eastern Avenue

18.

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) Malnutrition

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATH

2 1/2 Mos.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11-6-1950, to 11-7-1950, that I last saw the
deceased alive on 11-7-1950 and that death occurred at 12.05a., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

Baltimore City Hospital
4940 Eastern Avenue

23C. DATE SIGNED

11-20-50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Cremation

24B. DATE

Nov. 17, 1950

24C. NAME OF CEMETERY OR CREMATORY

B.C.H. Crematory

24D. LOCATION (City, town, or county)

4940 Eastern Ave. Balto. Md.

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

VS 150

To be approved by the Medical Examiner

158

CERTIFICATE OF DEATH

100-

100-

100-

100-

100-

100-

100-

100-

100-

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100-

100-

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100-

100-

100-

**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

50-10101

Registered No. _____

IRTH NO. 50-23669

NAME OF DECEASED
(Type or Print)

Baby Girl, Matthews

2. DATE
OF
DEATH

Nov. 7, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Baltimore City Hospitals
4940 Eastern Avenue

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE **Maryland**
B. COUNTY _____

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore **11-07**

D. STREET ADDRESS (If rural, give location)
Mayfair Hotel **Charles St. Bldg**

c. Length of stay in Baltimore

Life

Yrs.
Mos.
Days

5. SEX
Female

6. COLOR OR RACE
White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)
Single

8. DATE OF BIRTH
Nov. 4, 1950

9. AGE (In years last birthday)

If Under 1 Year
Months: Days

If Under 24 Hours
Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)
Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Clifton Matthews

14. MOTHER'S MAIDEN NAME

Ruth Marie Tarver

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS
Records- B C H 4940 Eastern Ave

18. **762.5**

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) **Atelectasis**

3 Days

OR TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) **Prematurity**

3 Days

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from **11-4** **150** to **11-7**, 19**50**, that I last saw the deceased alive on **11-7**, 19**50**, and that death occurred at **7:45 PM** **m.**, from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)
Cremated

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

Nov. 17, 1950

B.C.H. Crematory

4940 Eastern Avenue

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

NOV 27 1950

VS 150

159.0

MEDICAL CERTIFICATION

From B.C.H.

July 7640

Family & Childs

Mad 7330

ES.

535

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10102

Registered No. _____

BIRTH NO. 50-10102-23841

1. NAME OF DECEASED (Type or Print) Baby Girl "A" - Jane Snowden		2. DATE OF DEATH 11-7-50	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY X	
B. FULL NAME OF HOSPITAL OR INSTITUTION Baltimore City Hospitals 4940 Eastern Avenue		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore	
c. Length of stay in Baltimore Life		D. STREET ADDRESS (If rural, give location) 2601 Spelman Rd. (26)	
5. SEX F	6. COLOR OR RACE N	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH Nov. 2, 1950
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) -
13. FATHER'S NAME Mathew Mc Collugh		11. BIRTHPLACE (State or foreign country) Maryland	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		12. CITIZEN OF WHAT COUNTRY?	
16. SOCIAL SECURITY NO.		14. MOTHER'S MAIDEN NAME Jane Thomas	
17. INFORMANT Baltimore City Hospitals Records: 4940 Eastern Avenue			

18. 776 X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Prematurity DUE TO		INTERVAL BETWEEN ONSET AND DEATH 5 Days
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION 0		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from **11-2-**, 19 **50**, to **11-7-**, 19 **50**, that I last saw the deceased alive on **11-7-**, 19 **50**, and that death occurred at **4.30 p.m.**, from the causes and on the date stated above.

23A. SIGNATURE <i>[Signature]</i>		23B. ADDRESS 4940 Eastern Avenue	23C. DATE SIGNED 11-17-50
24A. BURIAL, CREMATION, REMOVAL (Specify) cremated	24B. DATE Nov. 17, 1950	24C. NAME OF CEMETERY OR CREMATORY B. C. H. Crematory	24D. LOCATION (City, town, or county) (State) 4940 Eastern Ave.
DATE RECEIVED BY LOCAL REGISTRAR NOV 27 1950	REGISTRAR'S SIGNATURE <i>[Signature]</i>	25. FUNERAL DIRECTOR 159.0	

30-10185

DEPARTMENT OF HEALTH - CIVIL

CERTIFICATE OF DEATH

FILE NO.

DATE

NAME OF DECEASED

AGE

SEX

RACE

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

OCCUPATION

CAUSE OF DEATH

MANNER OF DEATH

DATE OF DEATH

PLACE OF DEATH

TIME OF DEATH

TEMPERATURE

PULSE

BLOOD PRESSURE

WEIGHT

HEIGHT

HAIR

EYES

TEETH

SKIN

INTERNAL ORGANS

EXTERNAL ORGANS

LABORATORY TESTS

PATHOLOGICAL FINDINGS

CLINICAL FINDINGS

DIAGNOSIS

TREATMENT

PROGNOSIS

REMARKS

SIGNATURE OF PHYSICIAN

DATE OF SIGNATURE

PLACE OF SIGNATURE

TIME OF SIGNATURE

TEMPERATURE

PULSE

BLOOD PRESSURE

WEIGHT

HEIGHT

HAIR

EYES

TEETH

SKIN

652

50-10103

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10103

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Baby Boy Branch- Lucille		2. DATE OF DEATH 11-14-50	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Ave.		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore	
c. Length of stay in Baltimore 16 days Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) 521 Sharp St.- South	
5. SEX M	6. COLOR OR RACE Negro	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH Oct. 30, 1950
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 16
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Ellwood Branch		14. MOTHER'S MAIDEN NAME Lucille Garris	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT B. C. H. Records, 4940 Eastern Ave.		ADDRESS	

18. 76 yrs. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Atelectasis DUE TO Prematurity	INTERVAL BETWEEN ONSET AND DEATH 14 Days 14 Days
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) Prematurity DUE TO (C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **Oct. 30**, 19 **50** to **Nov. 14**, 19 **50** that I last saw the deceased alive on **Nov. 14**, 19 **50**, and that death occurred at **6AM** m., from the causes and on the date stated above.

23A. SIGNATURE <i>[Signature]</i>	23B. ADDRESS 4940 Eastern Ave.	23C. DATE SIGNED 11-16-50
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24A. BURIAL, CREMATION, REMOVAL (Specify) Cremated	24B. DATE Nov. 16, 1950	24C. NAME OF CEMETERY OR CREMATORY B / C. Hosp. Crematory	24D. LOCATION (City, town, or county) (State) 4940 Eastern Ave.
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DATE RECEIVED BY LOCAL REGISTRAR NOV 27 1950	REGISTRAR'S SIGNATURE <i>[Signature]</i>	25. FUNERAL DIRECTOR 0102	ADDRESS
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VS 150

159.0

MEDICAL CERTIFICATION

20-51103

CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Race	
4. Date of birth		5. Date of death		6. Place of death	
7. Cause of death		8. Manner of death		9. Signature of physician	
10. Signature of registrar		11. Signature of informant		12. Date of registration	

516
50-10104BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10104

Registered No.

BIRTH NO. 50-24780

1. NAME OF DECEASED (Type or Print) Baby Boy "A" Camper- Lorraine		2. DATE OF DEATH Nov. 17, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Avenue		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore	
c. Length of stay in Baltimore Life Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) 17 N. Bond St. (31)	
5. SEX M	6. COLOR OR RACE N	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH Nov. 17, 1950
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) - Months - Days - 54
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Ed. Sheppard		14. MOTHER'S MAIDEN NAME Sarah Camper	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Baltimore City Hospitals Records: 4940 Eastern Avenue		ADDRESS	

18. 762.5 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	CAUSE OF DEATH (A) Foetal Atelectasis DUE TO (B) Prematurity-Inmaturity DUE TO (C)	INTERVAL BETWEEN ONSET AND DEATH 54min 54min.
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19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE <input type="checkbox"/> AT WORK		21F. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 11-17, 1950, to 11-17, 1950, that I last saw the deceased alive on 11-17, 1950, and that death occurred at 5.10pm, from the causes and on the date stated above.

23A. SIGNATURE R. P. Rozen M. D.	23B. ADDRESS 4940 Eastern Avenue	23C. DATE SIGNED 11-21-50
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24A. BURIAL, CREMATION, REMOVAL (Specify) Cremated	24B. DATE 11-21-50 9am	24C. NAME OF CEMETERY OR CREMATORY Baltimore City Hospitals	24D. LOCATION (City, town, or county) (State) 4940 Eastern Ave. Balto, Md.
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DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
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NOV 27 1950

VS 150

159.0

CERTIFICATE OF DEATH

10-10101

<p>1. Name of deceased</p>		<p>2. Sex</p>		<p>3. Age</p>		<p>4. Date of death</p>	
<p>5. Place of death</p>		<p>6. Cause of death</p>		<p>7. Manner of death</p>		<p>8. Signature of physician</p>	
<p>9. Signature of registrar</p>		<p>10. Signature of informant</p>		<p>11. Signature of witness</p>		<p>12. Signature of official</p>	

516

50-10105

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

BIRTH NO. 50-10105
143471
30-24781

1. NAME OF DECEASED (Type or Print) Baby Boy "B" Camper - Lorraine		2. DATE OF DEATH Nov. 17, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY	
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTE Baltimore City Hospitals 4940 Eastern Avenue		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore	
D. STREET ADDRESS (If rural, give location) 17 N. Bond St. (31)			
5. SEX M		6. COLOR OR RACE N	
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single		8. DATE OF BIRTH Nov. 17, 1950	
9. AGE (In years last birthday) -		10. Under 1 Year Months: Days: -	
11. Under 24 Hours Hours: Min. - 2 9			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	
13. FATHER'S NAME Ed. Sheppard		14. MOTHER'S MAIDEN NAME Sarah Camper	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Baltimore City Hospitals Records: 4940 Eastern Avenue		ADDRESS	

18. 762.5 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Foetal Atelectasis DUE TO		INTERVAL BETWEEN ONSET AND DEATH 2hrs-9min.
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Prematurity-Inmaturity DUE TO		2hrs-9min
(C)		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 11-17, 1950, to 11-17, 1950 that I last saw the deceased alive on 11-17, 1950, and that death occurred at 7.30pm., from the causes and on the date stated above.

23A. SIGNATURE M. D.		23B. ADDRESS 4940 Eastern Avenue		23C. DATE SIGNED 11-21-50	
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24A. BURIAL, CREMATION, REMOVAL (Specify) Cremated		24B. DATE 9am 11-21-50		24C. NAME OF CEMETERY OR CREMATORY Baltimore City Hospitals		24D. LOCATION (City, town, or county) (State) Md. 4940 Eastern Ave. Baltimore	
DATE RECEIVED BY LOCAL REGISTRAR NOV 27 1950		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR		ADDRESS	

20-10108

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

DATE 01-10-2001 BY 60322 UCBAW

10/10/01

1. NAME (Last, First, Middle)		2. DATE OF BIRTH		3. SEX	
4. PLACE OF BIRTH		5. OCCUPATION		6. EDUCATION	
7. MARITAL STATUS		8. RELIGION		9. RACE	
10. ETHNICITY		11. SOCIAL SECURITY NUMBER		12. CURRENT ADDRESS	
13. PREVIOUS ADDRESSES		14. EMPLOYMENT HISTORY		15. CRIMINAL RECORD	
16. FINANCIAL RECORD		17. HEALTH RECORD		18. PSYCHOSOCIAL RECORD	
19. EDUCATIONAL RECORD		20. MILITARY RECORD		21. OTHER RECORDS	

432

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10106

Registered No.

D. 143492

50-10106-24784

1. NAME OF DECEASED (Type or Print) Baby Boy, Fields - Lillie		2. DATE OF DEATH Nov. 19, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY	
B. FULL NAME OF (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Avenue		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore	
c. Length of stay in Baltimore Life Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) 1618 Eareckson Place	
5. SEX M	6. COLOR OR RACE N	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH Nov. 19, 1950
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) — If Under 1 Year: Months: Days If Under 24 Hours: Hours: Min. 3 35
13. FATHER'S NAME Julius Fields		11. BIRTHPLACE (State or foreign country) Maryland	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		12. CITIZEN OF WHAT COUNTRY?	
16. SOCIAL SECURITY NO.		14. MOTHER'S MAIDEN NAME Lillie Holt	
17. INFORMANT Baltimore City Hospitals Records: 4940 Eastern Avenue			

18. **762.5**

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) **Foetal Atelectasis**

DUE TO

INTERVAL BETWEEN ONSET AND DEATH
3hrs-35min

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) **Prematurity**

DUE TO

3hrs-35min

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **11-19**, 1950, to **11-19**, 1950, that I last saw the deceased alive on **11-19**, 1950, and that death occurred at **5:45a.m.**, from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

M. D.

4940 Eastern Avenue**11-21-50**

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

01-10108

THE STATE OF CALIFORNIA

CERTIFICATE OF DEATH

10108

1

10108

2



400
FD-143400
50-10107
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10107

Registered No. _____

50-24779

1. NAME OF DECEASED (Type or Print) Baby Girl Riley- Mabel		2. DATE OF DEATH Nov. 16, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY _____	
5. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION Baltimore City Hospitals 4940 Eastern Avenue		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore	
6. Length of stay in Baltimore Life		D. STREET ADDRESS (If rural, give location) 713 W. North Avenue	
5. SEX F	6. COLOR OR RACE N	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH Nov. 16, 1950
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) Months Days
13. FATHER'S NAME James Leighton		11. BIRTHPLACE (State or foreign country) Maryland	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		14. MOTHER'S MAIDEN NAME Mabel Riley	
16. SOCIAL SECURITY NO.		17. INFORMANT Baltimore City Hospitals Records: 4940 Eastern Avenue	

18. 762.5 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION, CAUSING IT.	CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH
	(A) Foetal Atelectasis DUE TO		20 hrs.
	(B) Prematurity DUE TO		20hrs.
(C)			

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 11-16, 19 50, to 11-17, 19 50, that I last saw the deceased alive on 11-17, 19 50, and that death occurred at 2:45 am, from the causes and on the date stated above.					
23A. SIGNATURE J. J. Crozer		23B. ADDRESS M. D. 4940 Eastern Avenue		23C. DATE SIGNED 11-21-50	
24A. BURIAL, CREMATION, REMOVAL (Specify) Cremated		24B. DATE 11-21-50		24C. NAME OF CEMETERY OR CREMATORY Baltimore City Hospitals	
24D. LOCATION (City, town, or county) (State) Balto. Md.		24E. NAME OF CEMETERY OR CREMATORY 4940 Eastern Ave.		24F. LOCATION (City, town, or county) (State)	
DATE RECEIVED BY LOCAL REGISTRAR NOV 27 1950		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR ADDRESS	

STATE OF TEXAS
COUNTY OF DALLAS

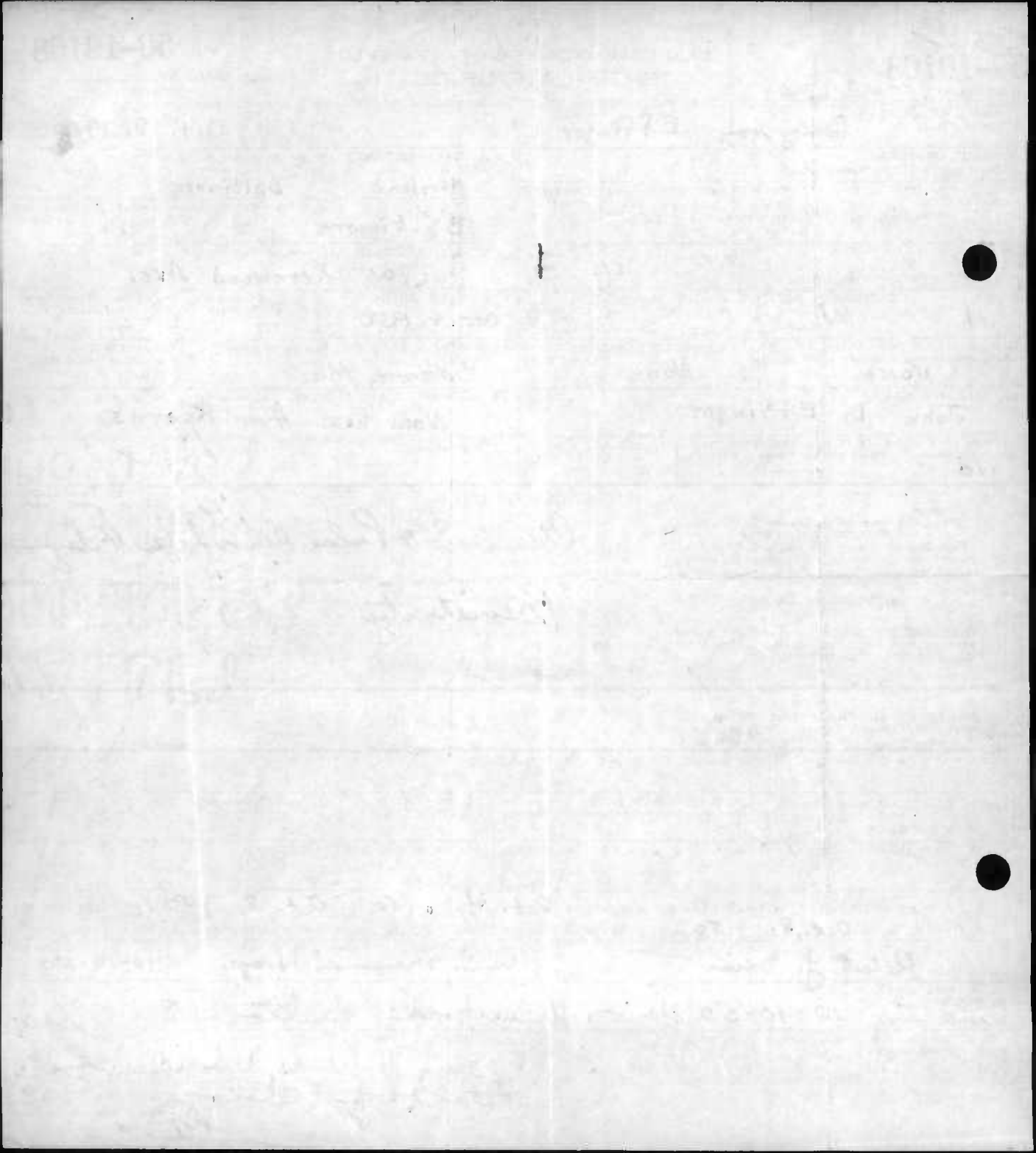
Name of Debtor		Address of Debtor	
Name of Creditor		Address of Creditor	
Amount of Debt		Date of Maturity	
Name of Assignor		Address of Assignor	
Name of Assignee		Address of Assignee	
Date of Assignment		Place of Assignment	
Signature of Debtor		Signature of Creditor	
Signature of Assignor		Signature of Assignee	
Notary Public		Notary Public	
Date of Filing		Place of Filing	
Filing Fee		Recorder's Fee	
Recorder's Name		Recorder's Address	
Recorder's Phone		Recorder's Fax	
Recorder's Email		Recorder's Website	
Recorder's Title		Recorder's Office	
Recorder's County		Recorder's State	
Recorder's Zip		Recorder's City	
Recorder's Country		Recorder's Continent	
Recorder's Region		Recorder's Subregion	
Recorder's District		Recorder's Subdistrict	
Recorder's Ward		Recorder's Subward	
Recorder's Precinct		Recorder's Subprecinct	
Recorder's Block		Recorder's Subblock	
Recorder's Lot		Recorder's Sublot	
Recorder's Parcel		Recorder's Subparcel	
Recorder's Tract		Recorder's Subtract	
Recorder's Section		Recorder's Subsection	
Recorder's Township		Recorder's Subtownship	
Recorder's Range		Recorder's Subrange	
Recorder's Meridian		Recorder's Submeridian	
Recorder's Survey		Recorder's Subsurvey	
Recorder's Plat		Recorder's Subplat	
Recorder's Map		Recorder's Submap	
Recorder's Plan		Recorder's Subplan	
Recorder's Diagram		Recorder's Subdiagram	
Recorder's Drawing		Recorder's Subdrawing	
Recorder's Photograph		Recorder's Subphotograph	
Recorder's Video		Recorder's Subvideo	
Recorder's Audio		Recorder's Subaudio	
Recorder's Document		Recorder's Subdocument	
Recorder's Record		Recorder's Subrecord	
Recorder's File		Recorder's Subfile	
Recorder's Folder		Recorder's Subfolder	
Recorder's Cabinet		Recorder's Subcabinet	
Recorder's Shelf		Recorder's Subshelf	
Recorder's Drawer		Recorder's Subdrawer	
Recorder's Box		Recorder's Subbox	
Recorder's Container		Recorder's Subcontainer	
Recorder's Vessel		Recorder's Subvessel	
Recorder's Object		Recorder's Subobject	
Recorder's Item		Recorder's Subitem	
Recorder's Piece		Recorder's Subpiece	
Recorder's Part		Recorder's Subpart	
Recorder's Component		Recorder's Subcomponent	
Recorder's Element		Recorder's Subelement	
Recorder's Factor		Recorder's Subfactor	
Recorder's Agent		Recorder's Subagent	
Recorder's Cause		Recorder's Subcause	
Recorder's Effect		Recorder's Subeffect	
Recorder's Result		Recorder's Subresult	
Recorder's Conclusion		Recorder's Subconclusion	
Recorder's End		Recorder's Subend	

152
50-10108
BIRTH NO. 50-21670BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50-10108
Registered No.

1. NAME OF DECEASED (Type or Print) Baby boy Effinger		2. DATE OF DEATH Oct. 8, 1950	
3. PLACE OF DEATH: a. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTE Union Memorial Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 27-11	
c. Length of stay in Baltimore 4 Days		d. STREET ADDRESS (If rural, give location) 4705 Kernwood Ave.	
5. SEX M	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) S	8. DATE OF BIRTH Oct. 4, 1950
9. AGE (In years last birthday)		10. CITIZEN OF WHAT COUNTRY?	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME John D. Effinger		14. MOTHER'S MAIDEN NAME Nora Rose Ann Kearns	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO.	
17. INFORMANT		ADDRESS	

18. 76y.5 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) <u>Atelectasis & Pulm. Hemorrhage</u> DUE TO (B) <u>Prematurity</u> DUE TO (C)	INTERVAL BETWEEN ONSET AND DEATH 4 days
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	

19a. DATE OF OPERATION 2		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21d. TIME (Month) (Day) (Year) (Hour) INJURY		21e. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Oct. 4, 1950 , to Oct. 8, 1950 , that I last saw the deceased alive on Oct. 8, 1950 , and that death occurred at m. , from the causes and on the date stated above.					
23a. SIGNATURE Robert J. Weiss		23b. ADDRESS Union Memorial Hosp.		23c. DATE SIGNED 10-10-50	
24a. BURIAL, CREMATION, REMOVAL (Specify) cremated		24b. DATE 10-10-50		24c. NAME OF CEMETERY OR CREMATORY Union Mem. Hosp.	
24d. LOCATION (City, town, or county) Balto - 18		24e. (State) Md.		24f. (State)	
DATE RECEIVED BY LOCAL REGISTRAR NOV 27 1950		REGISTRAR'S SIGNATURE Walter J. Williams, M.D.		25. FUNERAL DIRECTOR Wm. M. Urban Union Mem. Hosp.	
ADDRESS Dept. of Pathology		ADDRESS		ADDRESS	



631
50-10109

BRADFORD
BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10109
Registered No.

BIRTH NO. JASON S.

1. NAME OF DECEASED
(Type or Print) *James Bradford*

2. DATE OF DEATH *11/24/50*

3. PLACE OF DEATH
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE *MD.* B. COUNTY

B. FULL NAME OF HOSPITAL OR INSTITUTION *Univ. Hosp.*

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) *Worchester*

C. Length of stay in Baltimore
Yrs. Mos. Days

D. STREET ADDRESS (If rural, give location) *Berlin*

5. SEX *M* 6. COLOR OR RACE *W*

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)
Single

8. DATE OF BIRTH *June 9, 1902*

9. AGE (In years last birthday) *48* If Under 1 Year Months: Days: If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) *Prisoner* 10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) *MD*

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME *Elizabeth Bradford*

14. MOTHER'S MAIDEN NAME *Ruby Bertles*

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT *Mother* ADDRESS *Hospital Records*

18. *445 X*
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) *Renal Seis*

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) *insufficient Uremia*

DUE TO

(C) *Hypertension, Kidney*

INTERVAL BETWEEN ONSET AND DEATH

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION *0*

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH ☐

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *11-24-50*, 19__, to *11-24-50*, 19__, that I last saw the deceased alive on *11-24-50*, 19__ and that death occurred at *11:24 p.m.*, from the causes and on the date stated above.

23A. SIGNATURE *James Bradford*

23B. ADDRESS *Univ. Hosp.*

23C. DATE SIGNED *11/25/50*

24A. BURIAL, CREMATION, REMOVAL (Specify) *Burial*

24B. DATE *Nov 28, 1950*

24C. NAME OF CEMETERY OR CREMATORY *Protestant Cemty*

24D. LOCATION (City, town, or county) (State) *Newark, Md*

DATE RECEIVED BY LOCAL REGISTRAR *NOV 27 1950*

REGISTRAR'S SIGNATURE *William M. Williams*

25. FUNERAL DIRECTOR *Burke Funeral Home, Berlin, Md* ADDRESS

MEDICAL CERTIFICATION

101-101

101-101



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50-10110

143533

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50-10110

BIRTH NO.

1. NAME OF DECEASED (Type or Print) James Dix		2. DATE OF DEATH 11-25-50	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE Ma. B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION Baltimore City Hospitals 4940 Eastern Ave.		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore	
c. Length of stay in Baltimore 70 yrs.		D. STREET ADDRESS (If rural, give location) 1020 Union Ave.	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Wid.	8. DATE OF BIRTH Feb. 20, 1877
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Forman		10B. KIND OF BUSINESS OR INDUSTRY Cotton Duck Mill	9. AGE (In years last birthday) 73
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Thomas ?		14. MOTHER'S MAIDEN NAME Elizabeth ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. 216-03-4381	
17. INFORMANT B. C. H. Records, 4940 Eastern Ave.		ADDRESS	
18. 443 X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Cardiac failure DUE TO Arteriosclerosis Hypertensive Heart Disease Bronchiectasis, Pneumonia Bilaterally DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 2 mos.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION Nov 28/50		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 11-20-50 , 19 50 , to Nov. 25 , 19 50 , that I last saw the deceased alive on Nov. 25 , 19 50 , and that death occurred at 12.40 PM from the causes and on the date stated above.			
23A. SIGNATURE J. S. Rogers M. D.		23B. ADDRESS 4940 Eastern Ave.	
23C. DATE SIGNED 11-25-50			
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial	24B. DATE Nov 28/50	24C. NAME OF CEMETERY OR CREMATORY St. Marys (Hamden)	24D. LOCATION (City, town, or county) (State) Baltimore Md
25. FUNERAL DIRECTOR Frank H. Seitz		ADDRESS 814 N. 36th St.	

MEDICAL CERTIFICATION

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50-10111

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10111

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

ELVIN L. HARE

2. DATE
OF
DEATH

NOV 25 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION

ST. JOSEPH'S HOSP.

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE

MARYLAND

B. COUNTY

BALTIMORE

C. CITY OR TOWN (If outside corporate limits, with R.R. and give township)

D. STREET ADDRESS (If rural, give location)
4219 NICHOLAS AVE

c. Length of stay in Baltimore

LIFE

Yrs.
Mos.
Days

5. SEX

MALE

6. COLOR OR RACE

WHITE

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

MARRIED

8. DATE OF BIRTH

OCT 7 1887

9. AGE (In year:
last birthday)

63

10. Under 1 Year
Months: Days11. Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

PLUMBER

10B. KIND OF BUSINESS OR
INDUSTRY

AMERICAN BREWERY

13. FATHER'S NAME

GEORGE HARE

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

213-09-5757

17. INFORMANT

ADDRESS

ANNA E. HARE 4219 NICHOLAS AVE.

18. 420.11

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A)

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

11

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

22. TIME (Month) (Day) (Year) (Hour)
INJURY

23E. INJURY OCCURRED

23F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 1947 to October 1950, that I last saw the deceased alive on October 19 1950, and that death occurred at 11 A. m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

NOV 27 1950

VS 150

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MEDICAL CERTIFICATION

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RECEIVED

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57
Acet Room
50-10112-43891

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10112
Registered No.

1. NAME OF DECEASED (Type or Print) Frederick Klingenhoffer		2. DATE OF DEATH Nov. 26, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland Acet Room		4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) A. STATE Md. B. COUNTY Baltimore	
B. FULL NAME OF HOSPITAL OR INSTITUTION JOHNS HOPKINS HOSPITAL		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 2654	
c. Length of stay in Baltimore Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) 941 Rodman Way	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 3-27-1893
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Auto Painter		10B. KIND OF BUSINESS OR INDUSTRY Warden - Young	
13. FATHER'S NAME Louis Klingenhoffer		14. MOTHER'S MAIDEN NAME Louise Roberts	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) yes		16. SOCIAL SECURITY NO. 218-10-4540	
17. INFORMANT JOHNS HOPKINS HOSPITAL		ADDRESS	

18. 420.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Anterior Myocardial infarction	CAUSE OF DEATH (A) Anterior Myocardial infarction	INTERVAL BETWEEN ONSET AND DEATH 2 hrs
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B) Anterior Myocardial infarction	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	(C)	

19A. DATE OF OPERATION 0	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from 11-26-1950 to 11-26-1950 , that I last saw the deceased alive on 11-26-1950 and that death occurred at 9:30 a.m. from the causes and on the date stated above.		
23A. SIGNATURE Victor A. Mc Kusick M. O.	23B. ADDRESS JOHNS HOPKINS HOSPITAL	23C. DATE SIGNED 11/26/50

24A. BURIAL, CREMATION, REMOVAL (Specify) Buried	24B. DATE Nov 30-50	24C. NAME OF CEMETERY OR CREMATORY Sacred Heart Cem	24D. LOCATION (City, town, or county) (State) German Hill Baltimore
DATE RECEIVED BY LOCAL REGISTRAR NOV 27 1950	REGISTRAR'S SIGNATURE Wm Cook	25. FUNERAL DIRECTOR ADDRESS Wm Cook Inc. 1217 St Paul St	

VS 150
To be approved by Med. Exam **67083**
094a

MEDICAL CERTIFICATION

1008
No Medical Examiner's Case

Stanley H. Ouellette, M.D.
Asst. Med. Examiner,

620
0-10113

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10113

Registered No.

1. NAME OF DECEASED (Type or Print)		Charles Jirsa		2. DATE OF DEATH Nov. 23, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY			
B. FULL NAME OF HOSPITAL OR INSTITUTION 1252 E. North Ave.		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore			
C. Length of stay in Baltimore		D. STREET ADDRESS (If rural, give location) 1252 E. North Ave.			
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Separated	8. DATE OF BIRTH Nov. 4, 1890	9. AGE (In years last birthday) 60	10. Under 1 Year Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Insurance Collector		10B. KIND OF BUSINESS OR INDUSTRY Md. Service Co		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME Mathias Jirsa		14. MOTHER'S MAIDEN NAME Mary S. Jara	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Yes		16. SOCIAL SECURITY NO. W.W.1		17. INFORMANT Frank Jirsa, 2008 E. Federal St.	

18. 4221 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Cardiovascular Disease DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH (A) Arteriosclerotic Cardiovascular Disease DUE TO (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
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19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED m. WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that I took charge of the remains described above, held an <u>Inspection & Inq.</u> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> accident <input type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/> .					
23A. SIGNATURE Stanley K. Decker		23B. CHIEF MEDICAL EXAMINER..... M.D. ASSISTANT MEDICAL INVESTIGATOR.....		23C. DATE SIGNED Nov. 24, 1950	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/27/50		24C. NAME OF CEMETERY OR CREMATORY National	
24D. LOCATION (City, town, or county) Baltimore, Md.		24E. FUNERAL DIRECTOR Cook Inc 1217 St Paul		24F. ADDRESS	
DATE RECEIVED BY LOCAL REGISTRAR NOV 27 1950		REGISTRAR'S SIGNATURE		25. ADDRESS	

616
50-10114BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10114

Registered No.

BIRTH NO.		1. NAME OF DECEASED (Type or Print) Katherine Gruber		2. DATE OF DEATH Nov. 23, 1950	
3. PLACE OF DEATH: a. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY			
b. FULL NAME OF HOSPITAL OR INSTITUTION 1025 Somerset Street		c. CITY OR TOWN (If outside corporate limits, with RURAL and give township) Baltimore			
c. Length of stay in Baltimore		d. STREET ADDRESS (If rural, give location) 1025 Somerset Street			
5. SEX female	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) widowed	8. DATE OF BIRTH April 12, 1865	9. AGE (In years last birthday) 85	10. Under 1 Year Months: Days: Hours: Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Germany	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME George Stadler		14. MOTHER'S MAIDEN NAME Katherine Heim	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Lydia Gruber, 1025 Somerset Street	
18. 410X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) DUE TO (A) Coronary Embolus Myocardial Regurgitation Arterio Sclerosis Hypertension DUE TO (B) Chronic Interstitial Nephritis DUE TO (C) V		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH 1 hr 4 hrs 4 hrs 4 hrs	
19. DATE OF OPERATION None		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		21b. PLACE OF INJURY (e. g., In or about home, farm, factory, street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21d. TIME (Month) (Day) (Year) (Hour) INJURY		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Nov. 22, 1950, to Nov. 23, 1950, that I last saw the deceased alive on Nov. 23, 1950, and that death occurred at 6:30 P. m., from the causes and on the date stated above.					
23a. SIGNATURE J. F. A. Stevens		23b. ADDRESS 2878 Harford Rd.		23c. DATE SIGNED 11 24 50	
24a. BURIAL, CREMATION, REMOVAL (Specify) burial		24b. DATE 11/27/50		24c. NAME OF CEMETERY OR CREMATORY Western	
24d. LOCATION (City, town, or county) (State) Baltimore, Maryland		24e. DATE RECEIVED BY LOCAL REGISTRAR NOV 27 1950		24f. REGISTRAR'S SIGNATURE William J. Williams, M.D.	
24g. FUNERAL DIRECTOR Wm. Cook, Inc.		24h. ADDRESS 1217 St. Paul Street		24i. VS 150	

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563
50-10115
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10115
Registered No.

1. NAME OF DECEASED (Type or Print) FANNIE GERTRUDE RINEHART			2. DATE OF DEATH 11-25-1950		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE Maryland B. COUNTY BALTO.		
B. FULL NAME OF HOSPITAL OR INSTITUTION ST. Agnes Hospital			C. CITY OR TOWN Relay		
C. Length of stay in Baltimore			D. STREET ADDRESS (If rural, give location) 1707. Arlington ave. - Relay		
5. SEX Female	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH 8-30-1888	AGE (In years last birthday) 62	H Under 1 Year Months: Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10B. KIND OF BUSINESS OR INDUSTRY at home	11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Osceolla High			14. MOTHER'S MAIDEN NAME Mary Susan High		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no		16. SOCIAL SECURITY NO. no	17. INFORMANT Relay ADDRESS Mr. Elijah Pinehart 1707 Arlington Ave.		

18. 442 X 1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH
(A) ARTERIOSCLEROTIC CARDIO DUE TO VASCULAR DISEASE & HYPERTENSIVE RIGHT SIDE OF HEART		
(B) PULMONARY EDEMA DUE TO		
(C) NEPHROSCLEROSIS (MILD)		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION 2		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 11/21 , 1950, to 11/25 , 1950, that I last saw the deceased alive on 11-25 , 1950, and that death occurred at 8 P m., from the causes and on the date stated above.					
23A. SIGNATURE John H. Shaw		23B. ADDRESS Dr. John H. Shaw		23C. DATE SIGNED 11/25/50	

24A. BURIAL, CREMATION, REMOVAL (Specify) Removal		24B. DATE 11/28/50		24C. NAME OF CEMETERY OR CREMATORY Indian Mound Cem.		24D. LOCATION (City, town, or county) (State) Romney, W. Va.	
DATE RECEIVED BY LOCAL REGISTRAR NOV 27 1950		REGISTRAR'S SIGNATURE Wm. J. Pickens & Sons - Balto		25. FUNERAL DIRECTOR Wm. J. Pickens & Sons - Balto		ADDRESS 1312 md	

31-101-96

STATE OF NEW YORK

10-10-10

CLERK OF THE COURT

IN SENATE

10-10-10

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412
0-10116 *g.r.*BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50-10116
Registered No.

1. NAME OF DECEASED (Type or Print) <i>Thomas Phillips</i>		2. DATE OF DEATH <i>NOV 26 1950</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>OKLA.</i> B. COUNTY <i>V-33</i>	
5. FULL NAME OF HOSPITAL OR INSTITUTION <i>JOHN HOPKINS HOSPITAL</i>		6. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Tulsa</i>	
7. LENGTH OF STAY IN BALTIMORE		8. STREET ADDRESS (If rural, give location) <i>3107 E. Lattimore St.</i>	
9. SEX <i>male</i>	10. COLOR OR RACE <i>white</i>	11. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>S.</i>	12. DATE OF BIRTH <i>1-31-48</i>
13. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14. AGE (in years last birthday) <i>2</i>	
15. KIND OF BUSINESS OR INDUSTRY		16. BIRTHPLACE (State or foreign country) <i>Billingham, Wash.</i>	
17. FATHER'S NAME <i>Jack Phillips</i>		18. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
19. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		20. MOTHER'S MAIDEN NAME <i>Virginia Cummings</i>	
21. SOCIAL SECURITY NO.		22. INFORMANT <i>JOHN HOPKINS HOSPITAL</i>	
23. CAUSE OF DEATH 18. <i>754.4</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <i>Operation for</i> DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <i>(A) Congenital heart disease, valvular pulmonary stenosis</i> DUE TO <i>Cong.</i>		24. INTERVAL BETWEEN ONSET AND DEATH <i>36 hrs.</i>	
25. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
26. DATE OF OPERATION <i>11-29-50</i>		27. MAJOR FINDINGS OF OPERATION <i>Pulmonic stenosis.</i>	
28. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
29. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		30. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	
31. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
32. TIME (Month) (Day) (Year) (Hour) INJURY		33. INJURY OCCURRED	
34. WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		35. HOW DID INJURY OCCUR?	
36. I hereby certify that I attended the deceased from <i>11-20-1950</i> to <i>11-26-1950</i> , that I last saw the deceased alive on <i>11-26-1950</i> , and that death occurred at <i>12:10 AM.</i> , from the causes and on the date stated above.			
37. SIGNATURE <i>W. Morrow</i>		38. ADDRESS <i>JOHN HOPKINS HOSPITAL</i>	
39. DATE RECEIVED BY LOCAL REGISTRAR <i>NOV 27 1950</i>		40. REGISTRAR'S SIGNATURE <i>Wm. J. Dickener & Son - Balto Md.</i>	
41. FUNERAL DIRECTOR <i>1572</i>		42. ADDRESS	

20-10-1918

20-10-1918

[Faint, illegible handwriting throughout the page, likely bleed-through from the reverse side. The text is mostly horizontal and spans the width of the page.]

212

50-10117

BIRTH NO. 50-24640

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50-10117

1. NAME OF DECEASED (Type or Print) BRUCE JACK FISCHBACH			2. DATE OF DEATH November 25, 1950			
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY			
B. FULL NAME OF HOSPITAL OR INSTITUTION Union Memorial Hospital			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore			
C. Length of stay in Baltimore Yrs. Mos. Days			D. STREET ADDRESS (If rural, give location) 3813 Beech Avenue			
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) single	8. DATE OF BIRTH Nov. 15, 1950	9. AGE (In years last birthday) 10	10. Under 1 Year Months: Days 10	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none			10B. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME Jack T. Fischbach			14. MOTHER'S MAIDEN NAME Gloria Jane Belt			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.			
17. INFORMANT Mr. Jack T. Fischbach - 3813 Beech Ave.			ADDRESS			
18. 7544 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Congenital heart disease DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.						INTERVAL BETWEEN ONSET AND DEATH
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		
22. I certify that I took charge of the remains described above, held an <u>Autopsy</u> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: <u>natural causes</u> <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .						
23A. SIGNATURE <i>Russell S. Fisher</i> M.D.		23B. CHIEF MEDICAL EXAMINER..... <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER..... <input type="checkbox"/> MEDICAL INVESTIGATOR..... <input type="checkbox"/>		23C. DATE SIGNED Nov. 25, 1950		
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial	24B. DATE 11/27/50	24C. NAME OF CEMETERY OR CREMATORY Druid Ridge Cem.		24D. LOCATION (City, town, or county) (State) Pikesville, Md.		
DATE RECEIVED BY LOCAL REGISTRAR NOV 27 1950		REGISTRAR'S SIGNATURE <i>Walter J. ...</i>		25. FUNERAL DIRECTOR <i>Wm. J. ...</i> ADDRESS <i>157e ...</i>		

MEDICAL CERTIFICATION

152

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10118

Registered No.

BIRTH NO. 50-10118

1. NAME OF DECEASED (Type or Print) HARRIETT ELIZABETH SPENCER			2. DATE OF DEATH Nov. 25, 1950		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY		
B. FULL NAME OF DECEASED (If not in hospital or institution, give street address or location) Hood Nursing Home 5313 Edmondson Ave.			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore		
c. Length of stay in Baltimore Yrs. Mos. Days			D. STREET ADDRESS (If rural, give location) 5313 Edmondson Ave.		
5. SEX female	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) widowed	8. DATE OF BIRTH Dec. 3, 1870	9. AGE (In years last birthday) 79	If Under 1 Year Months: Days If Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY at home	11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Ardhibald Atkinson			14. MOTHER'S MAIDEN NAME Mary Frances Dews		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) -		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS Mr. Arthur Spencer - Ruxton 4, Md.		

18. 4 yrs. 1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH Aspiration C. V. Disease DUE TO Arterio Sclerosis DUE TO INTERVAL BETWEEN ONSET AND DEATH 1 mon	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	

19A. DATE OF OPERATION 11-20-50		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED m. WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 11-20-50 to 11-25-50 , that I last saw the deceased alive on 11-25-50 , and that death occurred at 11:45 A.M. , from the causes and on the date stated above.					
23A. SIGNATURE James H. Lawrence M. D.		23B. ADDRESS Caton Avenue		23C. DATE SIGNED 11-26-50	

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/27/50		24C. NAME OF CEMETERY OR CREMATORY Loudon Park		24D. LOCATION (City, town, or county) (State) Balto., Md.	
DATE RECEIVED BY LOCAL REGISTRAR NOV 27 1950		REGISTRAR'S SIGNATURE William H. Williams		25. FUNERAL DIRECTOR Wm. J. Fickner		ADDRESS Wm. J. Fickner - Balto.	

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8-101-50

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50-10119

50-10119

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

MABLE YEWELL FREEMAN

2. DATE
OF
DEATH

11/25/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION

Home Hosp.

c. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

Fem.

6. COLOR OR RACE

W

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

M.

8. DATE OF BIRTH

Nov. 6, 1903

9. AGE (In years
last birthday)

47

If Under 1 Year
Months Days Hours Min.10. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR
INDUSTRY

Housewife

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Henry Jewell

14. MOTHER'S MAIDEN NAME

Annie E. Prather

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mr. Guy R. Freeman 2721 St. Paul St.

18.

171X 1

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A)

Circulatory Collapse, Disturbance

DUE TO

(over)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

Metastatic Carcinoma

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11-24-50, 19__, to 11-25-50, 19__, that I last saw the
deceased alive on 11-25-50, 19__, and that death occurred at 5:40 a.m., from the causes and on the date stated above.

23A. SIGNATURE

M. D.

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

Burial

11/27/50

Greenmount Cem.

Balto., Md.

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

NOV 27 1950

Wilmington Williams, Md.

26m. J. Pickens & Sons Balto Md

VS 150

48a

MEDICAL CERTIFICATION

"Carcinoma of the cervix with erosion into the bladder, and obstruction into the sigmoid."

"The diabetes mellitus is secondary."

See Document File 50-10119 for corrective authority

12/6/50

ES

255
50-10120BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50-10120
Registered No.

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH	
		Walton Herbert McCommons		November 25, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY			
B. FULL NAME OF HOSPITAL OR INSTITUTION 3129 Keswick Road		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore			
C. Length of stay in Baltimore 40 years		D. STREET ADDRESS (If rural, give location) 3129 Keswick Road			
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH October 31, 1878	9. AGE (in years last birthday) 72	10. Under 1 Year Months: Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer Pa. R.R.		10B. KIND OF BUSINESS OR INDUSTRY Retired 4 years		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U S A		13. FATHER'S NAME Robert L. McCommons		14. MOTHER'S MAIDEN NAME Adelaide A. Gorrell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. 717-07-8742		17. INFORMANT ADDRESS Mrs. Lulu B. McCommons 3139 Keswick Road	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 144X CAUSE OF DEATH (A) Metastatic Carcinoma DUE TO Ovarian & rectal glands at chest (B) Carcinoma of hard palate DUE TO (C) of hard palate INTERVAL BETWEEN ONSET AND DEATH					
19. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from June 15, 1950, to Nov 25, 1950, that I last saw the deceased alive on Nov 25, 1950, and that death occurred at 5:45 P. M., from the causes and on the date stated above.					
23A. SIGNATURE W. H. Williams		23B. ADDRESS 3929 Chestnut St. (11) M. O.		23C. DATE SIGNED Nov. 26-50	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE Nov. 28, 1950		24C. NAME OF CEMETERY OR CREMATORY Mountain Christian	
24D. LOCATION (City, town, or county) (State) Harford Co., Maryland		24E. DATE RECEIVED BY LOCAL REGISTRAR NOV 27 1950		24F. REGISTRAR'S SIGNATURE Huntington Williams	
24G. FUNERAL DIRECTOR Burgee Funeral Home		24H. ADDRESS 3631 Falls Road		24I. SIGNATURE Norace F. Burgee	
24J. 54150		24K. 45c			

Was there any indication
in clinical record of probable
primary site of malignancy?

Primary site: Carcinoma of hard palate treated at Kelly's Sanatorium
about two years before death

See Document File 50-10120
12/13/50 ES

12/13/50
Was there in clinical record any
indication of probable site of origin of malignancy?

Was the tbc arrested, smothered?

Are we correct in picturing the case with
cancer the underlying cause of death? or

AUTOPSY: Carcinoma right kidney with carcinomatosis involving the adrenals,
right ureter, bladder, mesentery, intestines, omentum, liver,
peritoneum, chest wall, pleura, heart, lungs and subcutaneous
tissues, cyst, kidney, cachexia.

12/13/50 ES

Tuberculosis: X-ray impression on Nov. 6, 1950 showed fibroid
pulmonary tbc. bilateral more marked on left.
Slight pleural thickening.

263
ES* 11-188
260
50-10122
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50-10122

1. NAME OF DECEASED (Type or Print) Hattie Mashart (mashar)			2. DATE OF DEATH 11-23-50		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 27-15		
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Avenue			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore		
C. Length of stay in Baltimore 30 Yrs.			D. STREET ADDRESS (If rural, give location) Cold Spring Lane Nursing Home		
5. SEX Female	6. COLOR OR RACE Negro	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widow	8. DATE OF BIRTH Oct. 10, 1877	9. AGE (In years, Months, Days) 73 ?	If Under 1 Year: Months: Days: If Under 24 Hours: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of worklog life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) S.C.	
13. FATHER'S NAME William Arnold			14. MOTHER'S MAIDEN NAME Georgianna ? Rose		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT 4940 Eastern Avenue Records* Balto, City Hospitals	

18. 216X and E 902.7 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) Ovarium tumor probably Cystadenoma DUE TO		INTERVAL BETWEEN ONSET AND DEATH 6 Mos.
ANTECEDENT CAUSES, DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) William V. Smith DUE TO (OR ASST. MEDICAL EXAMINER)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT				

19A. DATE OF OPERATION 11-13-50		19B. MAJOR FINDINGS OF OPERATION Subtrochanteric fracture, left Insertion of Blount Plate-		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) Nursing Home	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Cold Spring Lane Nursing Home		
21D. TIME (Month) (Day) (Year) (Hour) INJURY Oct. 31, 1950	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21F. HOW DID INJURY OCCUR? Fell getting in bed		
22. I hereby certify that I attended the deceased from 11-7 , 19 50 , to 11-23 , 19 50 , that I last saw the deceased alive on 11-23 , 19 50 , and that death occurred at 4:20 PM , from the causes and on the date stated above.				
23A. SIGNATURE J. S. Cohen M. D.		23B. ADDRESS 4940 Eastern Ave.		23C. DATE SIGNED 11-24-50
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial	24B. DATE 11/27/50	24C. NAME OF CEMETERY OR CREMATORY Int. Calvary	24D. LOCATION (City, town, or county) (State) A. A. County, Md	
DATE RECEIVED BY LOCAL REGISTRAR NOV 27 1950		25. FUNERAL DIRECTOR Joseph S. Vols. Jr ADDRESS 1304 N. Central		

VS 150 TO BE APPROVED BY THE MEDICAL EXAMINER

186a

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240
50-10123BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

X Registered No. 50-10123

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Buzzell, Mr. Harry C.		2. DATE OF DEATH 11/26/50	
3. PLACE OF DEATH: a. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. FULL NAME OF (If not in hospital or institution, give street address or location) Church Home of Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) SPARROWS Point 53-00	
c. Length of stay in Baltimore 50 yrs		d. STREET ADDRESS (If rural, give location) 320 E. St.	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH Sept. 22, 1877
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman - Steel Mill		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 73 yrs.
13. FATHER'S NAME Buzzell, Eugene		11. BIRTHPLACE (State or foreign country) PENNSYLVANIA	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Unknown		12. CITIZEN OF WHAT COUNTRY? USA	
16. SOCIAL SECURITY NO.		14. MOTHER'S MAIDEN NAME Rachel Wright	
17. INFORMANT Allen Buzzell		ADDRESS 320 E. Sparrows Pt.	

CAUSE OF DEATH

18. **153X1**
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) **Adenocarcinoma of Colon**
DUE TO **With Metastasis**

INTERVAL BETWEEN ONSET AND DEATH

Oct, 1949
to Nov, 1950

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)
DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION 11/19/49		19B. MAJOR FINDINGS OF OPERATION 1 Resection Tumor of Descending Colon - Open Anastomosis		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from **11/19**, 19**50**, to **11/26**, 19**50**, that I last saw the deceased alive on **11/25**, 19**50**, and that death occurred at **1:46** A. M., from the causes and on the date stated above.

23A. SIGNATURE W. Reed Carroll		23B. ADDRESS M. D. Church Home of Hospital		23C. DATE SIGNED 11/26/50	
24A. BURIAL, CREMATION, REMOVAL (Specify) Removal		24B. DATE Nov 28/50		24C. NAME OF CEMETERY OR CREMATORY Chestnut Level	
24D. LOCATION (City, town, or county) (State) Lancaster Co Pa		25. FUNERAL DIRECTOR William H. Williams, Inc.		ADDRESS 2112 Dumlair	

NOV 27 1950

VS 150

523 3A

0462

MEDICAL CERTIFICATION

623

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10124

Registered No.

BIRTH NO. 50-10124

1. NAME OF DECEASED (Type or Print) JAMES FORREST		2. DATE OF DEATH November 19, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 18-02	
B. FULL NAME OF (If not in hospital or institution, give street address or location) Provident Hospital		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore	
c. Length of stay in Baltimore Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) 434 N. Arlington Avenue	
5. SEX Male	6. COLOR OR RACE Colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Dec. 10, 1893
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10B. KIND OF BUSINESS OR INDUSTRY General	9. AGE (In years last birthday) 57 56
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes June 1918-May 1919		16. SOCIAL SECURITY NO.	
17. INFORMANT Evangeline Forrest		ADDRESS 454 N. Carrollton Ave.	

18. 340.3 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Purulent meningitis DUE TO (A) ANTECEDENT CAUSES (B) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	INTERVAL BETWEEN ONSET AND DEATH
--	----------------------------------

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE <i>William V. Lovett</i>	23B. CHIEF MEDICAL EXAMINER..... M.D. ASSISTANT MEDICAL EXAMINER..... MEDICAL INVESTIGATOR.....	23C. DATE SIGNED 11-20-50
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial	24B. DATE Nov. 22, 1950	24C. NAME OF CEMETERY OR CREMATORY Baltimore National
24D. LOCATION (City, town, or county) (State) Baltimore, Md.		

DATE RECEIVED BY LOCAL REGISTRAR NOV 27 1950	REGISTRAR'S SIGNATURE <i>Hampton J. Williams</i>	25. FUNERAL DIRECTOR Joseph L. Rest	ADDRESS 1200 McCulloh St. Baltimore, Md.
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151-1

CERTIFICATE OF DEATH

151-1

<p>1. Name of deceased</p>		<p>2. Sex</p>		<p>3. Age</p>	
<p>4. Date of death</p>		<p>5. Time of death</p>		<p>6. Place of death</p>	
<p>7. Cause of death</p>		<p>8. Manner of death</p>		<p>9. Signature of physician</p>	
<p>10. Signature of registrar</p>		<p>11. Signature of informant</p>		<p>12. Signature of witness</p>	

536
50-10125
BIRTH NO.BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50-10125

1. NAME OF DECEASED (Type or Print) MARTHA HUNTER			2. DATE OF DEATH November 22, 1950		
3. PLACE OF DEATH: a. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Maryland b. COUNTY 16-02		
b. FULL NAME OF HOSPITAL OR INSTITUTION 1141 N. Gilmore Street			c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore		
c. Length of stay in Baltimore Yrs. Mos. Days			d. STREET ADDRESS (If rural, give location) 1141 N. Gilmore Street		
5. SEX female	6. COLOR OR RACE colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) widowed	8. DATE OF BIRTH May 10, 1897	9. AGE (In years last birthday) 53	If Under 1 Year Months Days If Under 24 Hours Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Banks County, Georgia		12. CITIZEN OF WHAT COUNTRY? U. S.
13. FATHER'S NAME Jack Hargrove			14. MOTHER'S MAIDEN NAME Frances Crawford		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 250 14 1781	17. INFORMANT Hazel Sykes ADDRESS 543 Mc Mechen St.		

18. 331X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) Cerebral hemorrhage, right DUE TO (B) _____ DUE TO (C) _____	INTERVAL BETWEEN ONSET AND DEATH
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21d. TIME (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I certify that I took charge of the remains described above, held an <u>autopsy</u> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .					
23a. SIGNATURE RS Fisher		23b. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> MEDICAL INVESTIGATOR <input type="checkbox"/>		23c. DATE SIGNED Nov. 22, 1950	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE Nov. 25, 1950		24c. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cemetery	
24d. LOCATION (City, town, or county) (State) Mt. Winans		25. FUNERAL DIRECTOR Joseph C. Russell Baltimore 1200 Mc Culloch st OP3a			
DATE RECEIVED BY LOCAL REGISTRAR NOV 27 1950		REGISTRAR'S SIGNATURE Huntington Williams		ADDRESS	

V S 151
720FA

355

0-10126

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10126

Registered No.

1. NAME OF DECEASED
(Type or Print)

ELLA MAJ. DITMAN

2. DATE
OF
DEATH

11-26-1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR INSTITUTE

ST. Agnes Hospital

C. Length of stay in Baltimore

Life

Yrs.
Mos.
Days

5. SEX

Female

6. COLOR OR RACE

white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

married

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore County

D. STREET ADDRESS (If rural, give location)

6309 Windsor Mill Rd

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

8. DATE OF BIRTH

5-26-

9. AGE (in years last birthday)

70

11 Under 1 Year Months: Days

11 Under 24 Hours Hours: Min.

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

FRANK SMELTZER

14. MOTHER'S MAIDEN NAME

MOLLIE ALEXANDER

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Clarence Ditman 1315 Randwood Rd

18. 422.1

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)(A) ARTERIOSCLEROTIC CARDIO
DUE TO VASCULAR DISEASE & CONGESTIVE

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) RT. BASE
DUE TO TOXIC NODULAR GOITER
(C) HEPATO MEGLAY

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m.

WHILE AT WORK ☐NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from 11/18, 1950, to 11/26, 1950, that I last saw the deceased alive on 11/26, 1950, and that death occurred at 4:30 p.m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

NOV 27 1950

Huntington Williams, Jr.

Harry H. Witzke 4101 Edmondway

10-10-1963

RECEIVED

NOV 11 1963



10

10

220
50-10127

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10127
Registered No.

1. NAME OF DECEASED (Type or Print) VALENTY CZASZEWICZ		2. DATE OF DEATH Nov. 24, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION Johns Hopkins Hospital		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore	
C. Length of stay in Baltimore 48 Years		D. STREET ADDRESS (If rural, give location) 508 S. Bethel St. 3rd floor	
5. SEX M	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widower	8. DATE OF BIRTH Jan 9 1872
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		9. AGE (In years last birthday) 78	
10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Poland	
13. FATHER'S NAME unk.		12. CITIZEN OF WHAT COUNTRY? Poland	
14. MOTHER'S MAIDEN NAME unk.		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT Hosp. Records ADDRESS	

18. 4721 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Cardiovascular Disease DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		INTERVAL BETWEEN ONSET AND DEATH
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19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Inspection & Inq. thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE Stanley B. Durelsou M.D.		23B. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> MEDICAL INVESTIGATOR <input type="checkbox"/>		23C. DATE SIGNED Nov. 24, 1950
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial	24B. DATE Nov. 27/50	24C. NAME OF CEMETERY OR CREMATORY Holy Rosary Ceme	24D. LOCATION (City, town, or county) Balta. County	(State)
DATE RECEIVED BY LOCAL REGISTRAR NOV 27 1950		REGISTRAR'S SIGNATURE John M. Deber		25. FUNERAL DIRECTOR ADDRESS 401 S. Chester Street

093d

623

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10128

Registered No.

BIRTH NO. 10128

1. NAME OF DECEASED (Type or Print) Frances Ann Proctor			2. DATE OF DEATH Nov 23, 1950		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore		
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION 2539 Madison Ave			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore		
C. Length of stay in Baltimore 81 Yrs			D. STREET ADDRESS (If rural, give location) 2539 Madison Ave		
5. SEX Female	6. COLOR OR RACE Colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Jan 8, 1865	9. AGE (In years last birthday) 85	10. Under 1 Year Months: Days 11. Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (State or foreign country) Northumberland Co, Va		12. CITIZEN OF WHAT COUNTRY? U.S.A
13. FATHER'S NAME Edwards			14. MOTHER'S MAIDEN NAME Priscilla Watty		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) -		16. SOCIAL SECURITY NO. -	17. INFORMANT ADDRESS Mr. Charles A/ Proctor 2539 Madison Ave		

18. 470.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Coronary Occlusion DUE TO Arteriosclerosis DUE TO II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		INTERVAL BETWEEN ONSET AND DEATH 25 min ?
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19A. DATE OF OPERATION - 0	19B. MAJOR FINDINGS OF OPERATION -	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **June 1947**, to **Nov 23, 1950**, that I last saw the deceased alive on **Nov 21, 1950**, and that death occurred at **1:30 a. m.**, from the causes and on the date stated above.

23A. SIGNATURE H. P. Hughes	23B. ADDRESS 825 N. Fremont Av	23C. DATE SIGNED 11-27-50
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24A. BURIAL, CREMATION, REMOVAL (Specify) Burial	24B. DATE Nov 27, 1950	24C. NAME OF CEMETERY OR CREMATORY Mt. Calvary Cem.	24D. LOCATION (City, town, or county) (State) Baltimore, Md
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DATE RECEIVED BY LOCAL REGISTRAR NOV 27 1950	REGISTRAR'S SIGNATURE Walter J. Williams, M.D.	25. FUNERAL DIRECTOR Holland Funeral Home	ADDRESS 1631 Druid Hill Ave.
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MEDICAL CERTIFICATION

10-11-58

CERTIFICATE OF DEATH

Coronary Artery
Disease

872 N. Vermont St.
H. P. Murphy

420
50-10129BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10129

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Walsh, Joseph Leo

2. DATE
OF
DEATH

November 25, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF

HOSPITAL OR

RESIDENCE

St. Joseph's

C. Length of stay in Baltimore

Life

Yrs.
Mos.
Days

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Aug. 31, 1881

9. AGE (In years
last birthday)

69

10. Under 1 Year
Months: Days:11. Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Retired

FIREMAN

10B. KIND OF BUSINESS OR
INDUSTRY

Balto. City Fire Dept.

11. BIRTHPLACE (State or foreign country)

Baltimore

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

John Walsh

14. MOTHER'S MAIDEN NAME

Mary

?

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs Gertrude Walsh 27.7 Tivoly Avenue

18. 540.0

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A)

Peritonitis
ruptured gastric ulcerINTERVAL BETWEEN
ONSET AND DEATH

3 days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

Complete heart block - arteriosclerotic
heart disease

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e.g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from November 24, 1950 to November 25, 1950, that I last saw the
deceased alive on Nov. 25, 1950, and that death occurred at 4:05 P.M., from the causes and on the date stated above.

23A. SIGNATURE

Maddens Swinski

M. D.

23B. ADDRESS

1100 N. Caroline St.

23C. DATE SIGNED

Nov. 25, 1950

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

11-29-50

24C. NAME OF CEMETERY OR CREMATORY

New Cathedral Cemetery

24D. LOCATION (City, town, or county)

Baltimore, Md.

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

M. J. Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

403 S. Wolfe Street

650		SORAN		BALTIMORE CITY HEALTH DEPARTMENT		50-10130	
0-10130		CERTIFICATE OF DEATH		Registered No.		50-10130	
1. NAME OF DECEASED (Type or Print) GERTRUDE SORAN				2. DATE OF DEATH 11-25-50			
3. PLACE OF DEATH: A. Baltimore City, Maryland				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY 16			
B. FULL NAME OF (If not in hospital or institution, give street address or location) UNIV. HOSP.				C. CITY OR TOWN (If outside corporate limits, write U.S.A. and give township) BALTIMORE 15-38			
c. Length of stay in Baltimore				D. STREET ADDRESS (If rural, give location) 3502 POWHATAN DR			
5. SEX F	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) SINGLE	8. DATE OF BIRTH		9. AGE (In years last birthday) 80		If Under 1 Year Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) NYC.		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME Anne			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, oo or uokooow)		(If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Hans Reade	
18. 443X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH HYPERTENSIVE CARDIO-VASCULAR DISEASE & PULMONARY EDEMA				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 0		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from NOV 25, 1950 , to NOV 25, 1950 , that I last saw the deceased alive on NOV 25, 1950 , and that death occurred at 12:00 P.M. , from the causes and on the date stated above.							
23A. SIGNATURE John W. Klover M. D.				23B. ADDRESS Union Hosp		23C. DATE SIGNED 11-25-50	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE Nov 28/1950		24C. NAME OF CEMETERY OR CREMATORY Baltimore		24D. LOCATION (City, town, or county) (State) Baltimore Md.	
DATE RECEIVED BY LOCAL REGISTRAR NOV 27 1950		REGISTRAR'S SIGNATURE W. J. Williams, M.D.		25. FUNERAL DIRECTOR Harry R. Himmelfarb		ADDRESS 4204 Edgewood Ave	
VS 150							

093d

30-11100

STATE OF TEXAS

1-10



523

BIRTH NO. 10131

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10131

Registered No.

1. NAME OF DECEASED (Type or Print) Anna M. Wingate			2. DATE OF DEATH Nov. 24, 1950		
3. PLACE OF DEATH: A. Baltimore City, Maryland Baltimore			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 6-02		
B. FULL NAME OF HOSPITAL OR INSTITUTION 141 N. Luzerne Ave.			C. CITY OR TOWN (If outside corporate limits, write R.R.A.J. and give township) Baltimore		
c. Length of stay in Baltimore Life Yrs. Life Mos. Life Days Life			D. STREET ADDRESS (If rural, give location) 141 N. Luzerne Ave		
5. SEX F	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Aug. 31, 1885	9. AGE (In years last birthday) 65	II Under 1 Year Months: Days II Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY At Home	11. BIRTHPLACE (State or foreign country) Baltimore Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Joseph H. Kemp			14. MOTHER'S MAIDEN NAME Laura E. Baldwin		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) no		16. SOCIAL SECURITY NO. none	17. INFORMANT ADDRESS Charles E. Wingate 141 N. Luzerne		
18. 443X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) cerebro vascular accident DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. hypertensive cardio vas. disease DUE TO II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			INTERVAL BETWEEN ONSET AND DEATH 35 days 10 yrs.		
19A. DATE OF OPERATION 6		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE <input type="checkbox"/> AT WORK		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Oct 18, 1950 , to Nov 24, 1950 , that I last saw the deceased alive on Nov 24, 1950 , and that death occurred at 5:45 p.m. , from the causes and on the date stated above.					
23A. SIGNATURE Benton V. Lock MD M. D.		23B. ADDRESS 2936 E. Balto St.		23C. DATE SIGNED 11/25/50	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE Nov. 27, 1950		24C. NAME OF CEMETERY OR CREMATORY Greenmount Cemetery	
DATE RECEIVED BY LOCAL REGISTRAR NOV 27 1950		REGISTRAR'S SIGNATURE W. H. Sander		25. FUNERAL DIRECTOR ADDRESS H. Sander & Sons Inc. Baltimore Md.	

MEDICAL CERTIFICATION

093d

100-1

RECEIVED

[Faint, mostly illegible text and markings covering the page, including what appears to be a large 'X' or 'Z' in the lower left corner.]

152
0-10132BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10132

Registered No.

1. NAME OF DECEASED (Type or Print) CLARA E. EVANS			2. DATE OF DEATH 11/25/50		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore		
B. FULL NAME OF (If not in hospital or institution, give street address or location) INSTITUTION 100 W. Cold Spring Lane.			C. CITY OR TOWN (If outside corporate limits, write full name and give township) Baltimore		
C. Length of stay in Baltimore Yrs. Mos. Days			D. STREET ADDRESS (If rural, give location) 2021 Longwood Street		
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH 1868	9. AGE (In years last birthday) 82	If Under 1 Year Months: Days If Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Mo.	
13. FATHER'S NAME JOSUA EVANS			14. MOTHER'S MAIDEN NAME MARGARET (?)		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Mrs. Mabel Hudgins-3132 Belmont Ave	
18. 420.0 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) Myocardial Degeneration & insufficiency DUE TO first congestive failure arterio sclerosis, arterio plastic type (B) Heart disease with cardiac hypertrophy DUE TO and hypertension. (C) INTERVAL BETWEEN ONSET AND DEATH 1 month. several years.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Psy choses with cerebral arterio sclerosis.			2 years.		
19A. DATE OF OPERATION 0		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 1950 to Nov 25, 1950 , that I last saw the deceased alive on Nov 24, 1950 , and that death occurred at 8 A. m. , from the causes and on the date stated above.					
23A. SIGNATURE Wm Michel		23B. ADDRESS 1015 Poplar Grove St.		23C. DATE SIGNED Nov 27 1950	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/28/50		24C. NAME OF CEMETERY OR CREMATORY Greenmount	
24D. LOCATION (City, town, or county) city		24E. LOCATION (State) city			
DATE RECEIVED BY LOCAL REGISTRAR NOV 27 1950		REGISTRAR'S SIGNATURE William H. Williams, M.D.		25. FUNERAL DIRECTOR Wiedefeld & Son GREENMOUNT AVE & 22ND	

5-316

50-10133

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50-10133
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

David L. Stafford, Sr.

2. DATE
OF
DEATH

November 24, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE Md.

B. COUNTY

before admission)

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR INSTITUTION

1215 Ashland Ave.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Balto.

D. STREET ADDRESS (If rural, give location)

1215 Ashland Ave.

C. Length of stay in Baltimore

Life

Yrs.
Mos.
Days

5. SEX

M

6. COLOR OR RACE

C

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

M

8. DATE OF BIRTH

1897

9. AGE (in years
last birthday)

53

10. Under 1 Year
Months: Days11. Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Chauffeur

10B. KIND OF BUSINESS OR
INDUSTRY

PRODUCE (W)

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF
WHAT COUNTRY?

U S. A.

13. FATHER'S NAME

David Stafford

14. MOTHER'S MAIDEN NAME

Rebecca ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown)

no

(If yes, give war or dates of service)

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Eximia Stafford 1215 Ashland Ave

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)(A)
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B)
DUE TO
(C)II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH21B. PLACE OF INJURY (e.g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE
WORK ☐ AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2:30 P.M. to 2:45 P.M., 1950, that I last saw the
deceased alive on 11/20/50, and that death occurred at 2:45 P.M., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

NOV 27 1950

Geo. G. Kelson 1303 Presstman St,

68363

Geo. G. Kelson 1303 Presstman St,

Dr. Comally
13 E. Eager St.

T-656
50-10134BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50-10134

BIRTH NO.

1. NAME OF DECEASED (Type or Print) SARAH TURNER		2. DATE OF DEATH Nov 24, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland OSL, 4		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION JOHNS HOPKINS HOSPITAL		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE	
c. Length of stay in Baltimore		D. STREET ADDRESS (If rural, give location) 1230 N. STRICKER ST.	
5. SEX FEMALE	6. COLOR OR RACE COLORED	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED	8. DATE OF BIRTH 6-1-83
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	
13. FATHER'S NAME John Lincoln		14. MOTHER'S MAIDEN NAME Lizza Lincoln	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT		ADDRESS JOHNS HOPKINS HOSPITAL	

18. 540.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Perforated ulcer of stomach	CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO	INTERVAL BETWEEN ONSET AND DEATH 24 hrs.
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Chronic bronchiectasis		

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION 11-28-50		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from 11-23 19 50 , to 11-24 , 19 50 , that I last saw the deceased alive on 11-24 , 19 50 , and that death occurred at 5:30 P.M., from the causes and on the date stated above.				
23A. SIGNATURE Victor G. McKusick		23B. ADDRESS JOHNS HOPKINS HOSPITAL		23C. DATE SIGNED Nov. 25, 1950
24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE 11/28/50	24C. NAME OF CEMETERY OR CREMATORY mt Auburn	24D. LOCATION (City, town, or county) (State) md	
DATE RECEIVED BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE Geo. D. Nelson		25. FUNERAL DIRECTOR 1303
				ADDRESS Prestman St

NOV 27 1950
VS-150

117a

10-10-1914

10-10-1914

Capital of the

State of New York

Albany

October 10, 1914

My dear Sir:

I have the honor to acknowledge the receipt of your letter of the 9th inst. in relation to the proposed amendment to the Constitution of the State of New York, and in reply to inform you that the same has been referred to the proper authorities for their consideration.

I am, Sir, very respectfully,
Yours very truly,

Wm. W. Ladd,
Secretary of the State.

Very truly yours,
Wm. W. Ladd.

Wm. W. Ladd,
Secretary of the State.

Very truly yours,
Wm. W. Ladd.

Wm. W. Ladd,
Secretary of the State.

Very truly yours,
Wm. W. Ladd.

Wm. W. Ladd,
Secretary of the State.

G-640
50-10135BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10135

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

CLINTON CROWELL

2. DATE
OF
DEATH

11-27-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF
HOSPITAL OR
INSTITUTION (If not in hospital or institution, give street address or location)

UNIV. HOSP.

Yrs.
Mos.
Days

C. Length of stay in Baltimore

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

widowed

8. DATE OF BIRTH

Dec. 11, 1875

9. AGE (In years
last birthday)

74

10. Under 1 Year
Months: Days: Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Merchant (rtd)

10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

INDIANA

12. CITIZEN OF
WHAT COUNTRY?

U.S.

13. FATHER'S NAME

NORTH Crowell

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mr. Arthur Fraidin - 4009 Liberty Hgts. Av.

18. 332X1

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)(A) CEREBRAL THROMBOSIS
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) POS. BRAIN ABSCESS
DUE TO
(C)II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

PNEUMONITIS

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH21B. PLACE OF INJURY (e.g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11-25-50 to 11-27-50, that I last saw the
deceased alive on 11-27-50, and that death occurred at 3:30 p.m., from the causes and on the date stated above.

23A. SIGNATURE

John W. Stoner
M.D.

23B. ADDRESS

Univ. Hosp.

23C. DATE SIGNED

11-27-50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)
Burial

24B. DATE

11/28/50

24C. NAME OF CEMETERY OR CREMATORY

Lorraine Cem.

24D. LOCATION (City, town, or county)

Woodlawn, Md.

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

John J. Stoner & Sons - Balto
Md.

NOV 27 1950

J. W. Stoner, M.D.

290

0836

MEDICAL CERTIFICATION

[The body of the document contains several paragraphs of text that are extremely faint and illegible. The text appears to be a formal report or memorandum, possibly detailing a case or investigation. There are two large black circular marks on the right side of the page, which may be punch holes or redactions.]

M-262
50-10136BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10136

Registered No.

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH	
		LULAH SLATON MacGREGOR		Nov. 25, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md.			
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION Anderson Nursing Home 3606 Mohawk Ave.		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore			
C. Length of stay in Baltimore		D. STREET ADDRESS (If rural, give location) 20 E. Preston St.			
5. SEX female	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH Oct. 2, 1874	9. AGE (In years last birthday) 76	10. Under 1 Year Months: Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10B. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) Georgia	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME William Franklin Slaton		14. MOTHER'S MAIDEN NAME Nancy Jane Martin	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no		16. SOCIAL SECURITY NO. no		17. INFORMANT Mr. William A. MacGregor	
				ADDRESS 20 E. Preston St	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 163x1 Carcinoma of Lung.		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH About June 1949	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		Lung & skin infection from pneumonia.			
19A. DATE OF OPERATION - 0		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Jan 1925 to Nov 25, 1950, that I last saw the deceased alive on Nov 20, 1950, and that death occurred at 20 E. Preston St., from the causes and on the date stated above.					
23A. SIGNATURE William A. MacGregor		23B. ADDRESS M. D. 20 E. Preston St.		23C. DATE SIGNED 11/27/50	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/28/50		24C. NAME OF CEMETERY OR CREMATORY Woodlawn Cem.	
24D. LOCATION (City, town, or county) (State) Woodlawn, Md.		24E. FUNERAL DIRECTOR Wm. J. Pickens & Sons - Balto		24F. ADDRESS 047d Md.	
DATE RECEIVED BY LOCAL REGISTRAR NOV 27 1950		REGISTRAR'S SIGNATURE William A. MacGregor		25. FUNERAL DIRECTOR Wm. J. Pickens & Sons - Balto	

RECEIVED

U.S. DEPARTMENT OF AGRICULTURE

WASHINGTON, D. C.

1938

OFFICE OF THE SECRETARY

WASHINGTON, D. C.

TO THE SECRETARY

FROM THE SECRETARY

1938

1938

RECEIVED

U.S. DEPARTMENT OF AGRICULTURE

WASHINGTON, D. C.

1938

OFFICE OF THE SECRETARY

WASHINGTON, D. C.

1938

R-352
50-10137BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10137

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

ANTHONY RUDNICKI

2. DATE
OF
DEATH

Nov. 25, 1960

3. PLACE OF DEATH:

A. Baltimore City, Maryland 1727 Bank St.

B. FULL NAME OF
HOSPITAL OR
INSTITUTION (If not in hospital or institution, give street address or location)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Md.

C. CITY OR TOWN (If outside corporate limits write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1727 Bank St.

c. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

1885

9. AGE (in years
last birthday)

65

If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.10A. MALE OCCUPATION (Give kind of
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR
INDUSTRY

Confectionary Store (R) PROP.

13. FATHER'S NAME

Unknown

11. BIRTHPLACE (State or foreign country)

Poland

12. CITIZEN OF
WHAT COUNTRY?

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Walter Rudnicki

18. 422.2 I CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) DUE TO

Myocardial Insufficiency

INTERVAL BETWEEN
ONSET AND DEATH

6 days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

Chronic Myocarditis

8 yrs

(C)

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE
WORK AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan., 1940, to Nov. 25, 1960, that I last saw the deceased alive on , 19 , and that death occurred at m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

Burial

Nov. 28/60

Holy Rosary

Baltimore

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

OV 27-1950

VS 150

Antony J. Williams, M.D.

Fred W. Ozagowski - 1930 Eastern Ave.

2906A

093d

MEDICAL CERTIFICATION

10-10-1917

Dr. J. H. ...

At ...
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F-400
50-10138BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50-10138
Registered No.

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>WILLIAM FEELEY</i>		2. DATE OF DEATH <i>11/25/50</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <i>Ind.</i> B. COUNTY			
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <i>SOUTH BALTO. GEN. HOSP.</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township) <i>Baltimore</i>			
c. Length of stay in Baltimore		D. STREET ADDRESS (If rural, give location) <i>1822 Light Street</i>			
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>M</i>	8. DATE OF BIRTH <i>1/10/1893</i>	9. AGE (In years last birthday) <i>57</i>	If Under 1 Year Months: Days If Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Machinist</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>B & O R.R.</i>		11. BIRTHPLACE (State or foreign country) <i>Baltimore</i>	
13. FATHER'S NAME <i>John</i>		12. CITIZEN OF WHAT COUNTRY?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO.		14. MOTHER'S MAIDEN NAME <i>Anna McDermott</i>	
17. INFORMANT <i>Family - Same</i>		ADDRESS			
18. <i>150X I</i> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <i>(A) CARCINOMA OF ESOPHAGUS</i> DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <i>(B)</i> DUE TO <i>(C)</i>					INTERVAL BETWEEN ONSET AND DEATH
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>0</i>		19B. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDER- Lying <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY m.		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>9/29</i> , 19 <i>50</i> , to <i>11/25</i> , 19 <i>50</i> , that I last saw the deceased alive on <i>11/25</i> , 19 <i>50</i> , and that death occurred at <i>7:03 P.m.</i> , from the causes and on the date stated above.					
23A. SIGNATURE <i>William B. Cooper</i>		23B. ADDRESS <i>South Balto Gen. Hosp</i>		23C. DATE SIGNED <i>11/25/50</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>B</i>		24B. DATE <i>11/28/50</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill</i>	
DATE RECEIVED BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE <i>Arthur J. Williams, M.D.</i>		25. FUNERAL DIRECTOR <i>L. E. ...</i>	
				ADDRESS <i>- 130 E. Fort Ave.</i>	

NOV 27 1950

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William J. ...

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D-320
50-10139

50-10139

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED (Type or Print) <i>Grace Gilbert Dietz</i>			2. DATE OF DEATH Nov. 25, 1950		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>none</i> C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore</i> D. STREET ADDRESS (If rural, give location) <i>512 Rossiter Ave.</i>		
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <i>512 Rossiter Ave.</i>			c. Length of stay in Baltimore <i>45</i> Yrs. Mos. Days		
5. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>widowed</i>	8. DATE OF BIRTH <i>July 15, 1869</i>	9. AGE (in years last birthday) <i>81</i>	10. Under 1 Year Months: Days 11. Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>Harford County, Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S.</i>
13. FATHER'S NAME <i>John Crawford Thompson</i>			14. MOTHER'S MAIDEN NAME <i>Hester Ann Gilbert</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS <i>Mrs. Elinor D. Forestell-512 Rossiter Ave.</i>		

MEDICAL CERTIFICATION

18. <i>4221</i> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Anteriosclerotic Cardio-vascular Disease</i> DUE TO <i>Cerebral Hemorrhage</i> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			CAUSE OF DEATH INTERVAL BETWEEN ONSET AND DEATH <i>5 yr</i> <i>6 mo</i>		
19A. DATE OF OPERATION <i>0</i>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE <input type="checkbox"/> AT WORK		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>5-20</i> , 1950, to <i>11-25</i> , 1950, that I last saw the deceased alive on <i>11-24</i> , 1950, and that death occurred at <i>3:30 a. m.</i> , from the causes and on the date stated above.					
23A. SIGNATURE <i>R. D. Glenn</i>		23B. ADDRESS <i>11 E. Chase St.</i>		23C. DATE SIGNED	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i>		24B. DATE <i>11-27-50</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Woodlawn</i>	
24D. LOCATION (City, town, or county) (State) <i>Woodlawn, Md.</i>		24E. DATE RECEIVED BY LOCAL REGISTRAR <i>NOV 27 1950</i>		24F. REGISTRAR'S SIGNATURE <i>Wm. J. Williams, M.D.</i>	
24G. DATE RECEIVED BY LOCAL REGISTRAR <i>NOV 27 1950</i>		24H. REGISTRAR'S SIGNATURE <i>Wm. J. Williams, M.D.</i>		24I. FUNERAL DIRECTOR <i>R. Madison Mitchell</i>	
24J. ADDRESS <i>Hayre de Grace, Md.</i>		24K. ADDRESS <i>Hayre de Grace, Md.</i>		24L. ADDRESS <i>Hayre de Grace, Md.</i>	

Dr. Ruelley D. F. Lynn

500

50-10140

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50-10140
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Fennie Cohen

2. DATE
OF
DEATH

Nov 27, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence
A. STATE B. COUNTY before admission)

Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or
HOSPITAL OR location)
INSTITUTION 4613 ParkHeights AveC. CITY OR TOWN (If outside corporate limits, write RURAL and give
Baltimore township)

D. STREET ADDRESS (If rural, give location)

4613 ParkHeights Ave

c. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

WIDOW

8. DATE OF BIRTH

1860

9. AGE (In years
last birthday)

90

10 Under 1 Year
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

None

10B. KIND OF BUSINESS OR
INDUSTRY

None

11. BIRTHPLACE (State or foreign country)

Russie

12. CITIZEN OF
WHAT COUNTRY?

USA.

13. FATHER'S NAME

Solomon Spevick

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

David Cohen- Easton, Maryland

18. 450.0

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, ashenia, etc. It means the disease,
injury or complication which caused death.)

(A) DUE TO

Acute Cardiac failure

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

General atherosclerosis

II

(C) DUE TO

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
INJURY

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7/14, 1949 to 11/22, 1950, that I last saw the
deceased alive on 11/22, 1950, and that death occurred at 6 A. M. from the causes and on the date stated above.

23A. SIGNATURE

A. H. Hornstein

23B. ADDRESS

M. D.

204 E. Biddle St

23C. DATE SIGNED

11/27/50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

Removal

11/28/50

Mt. Sharon Cemetery

Philadelphia, Pa.

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

27/1950

Wilmington, Delaware

Sol. Levinson & Bros. - 1124-26 W. North Ave.

RECEIVED BY THE DEPT. OF THE ARMY

TO THE SECRETARY OF THE ARMY

FROM THE SECRETARY OF THE ARMY

SUBJECT: [Illegible]

DATE: [Illegible]

REFERENCE: [Illegible]

REMARKS: [Illegible]

SIGNED: [Illegible]

POSITION: [Illegible]

OFFICE: [Illegible]

BRANCH: [Illegible]

REGIMENT: [Illegible]

COMPANY: [Illegible]

PLATOON: [Illegible]

SECTION: [Illegible]

FILE NO.: [Illegible]

-4530-10141		BALTIMORE CITY HEALTH DEPARTMENT		50-10141	
BIRTH NO. 49-09522		CERTIFICATE OF DEATH		Registered No.	
1. NAME OF DECEASED (Type or Print) Jonathan Williams			2. DATE OF DEATH Nov. 26, 1950		
3. PLACE OF DEATH: a. Baltimore City, Maryland 1414 4 W - Rd.			4. USUAL RESIDENCE (Where deceased lived, if institution: residence) a. STATE Md b. COUNTY 3-01		
b. FULL NAME OF HOSPITAL OR INSTITUTION JOHN HOPKINS HOSPITAL			c. CITY OR TOWN Baltimore		
c. Length of stay in Baltimore Lief			d. STREET ADDRESS (If rural, give location) 7 S. Caroline St.		
5. SEX Male		6. COLOR OR RACE Colored		7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Child	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		8. DATE OF BIRTH 5-9-1949	
13. FATHER'S NAME Jonathan E. Evers		14. MOTHER'S MAIDEN NAME Katherine Williams		9. AGE (In years last birthday) 6	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO.		11. BIRTHPLACE (State or foreign country) Maryland	
				12. CITIZEN OF U.S.A. COUNTRY? U.S.A.	
				17. INFORMANT ADDRESS JOHN HOPKINS HOSPITAL	
18. 002X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH		
ANTECEDENT CAUSES			(A) Meningitis, Tuberculous		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.			DUE TO Pulmonary Tuberculosis		
			(B) Military Tuberculosis		
			(C) Lung, Spleen, Liver, Brain		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			INTERVAL BETWEEN ONSET AND DEATH		
19a. DATE OF OPERATION 2			19b. MAJOR FINDINGS OF OPERATION		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21d. TIME (Month) (Day) (Year) (Hour) INJURY			21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
21f. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from 11-23-1950 to 11-26-1950 that I last saw the deceased alive on 11-26-1950 and that death occurred at 1:14 P.M., from the causes and on the date stated above.					
23a. SIGNATURE Thomas C. McPherson M. D.			23b. ADDRESS JOHN HOPKINS HOSPITAL		23c. DATE SIGNED 11/27/50
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 11/29/1950	24c. NAME OF CEMETERY OR CREMATORY Mt Calvary Cem.		24d. LOCATION (City, town, or county) Brooklyn Md (State)
DATE RECEIVED BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR ADDRESS	
NOV 27 1950		Katherine Williams		Elmer A. Wilson 1000	
0136 Beatty					

11-1-11

(2)

Mr. J. H. ...
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11-1-11

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6590-10142

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50-10142
Registered No.

BIRTH NO. 50-17713

1. NAME OF DECEASED (Type or Print) CLARENCE SAMUEL BROWN			2. DATE OF DEATH Nov. 25, 1950		
3. PLACE OF DEATH: A. Baltimore City, Maryland Balto. City			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY		
5. FULL NAME OF HOSPITAL OR INSTITUTION Johns Hopkins Hospital			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto. City		
c. Length of stay in Baltimore Life			D. STREET ADDRESS (If rural, give location) 105 N. Durham St 6-04		
5. SEX M	6. COLOR OR RACE C	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) S	8. DATE OF BIRTH Aug. 23, 1950		9. AGE (In years last birthday) 2 23
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10B. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Baltimore Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Clarence Brown Sr.		
14. MOTHER'S MAIDEN NAME Muriel Gregory			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		
16. SOCIAL SECURITY NO.			17. INFORMANT Samuel Brown 105 N. Durham St		

18. 491X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Acute bronchitis and ANTecedent CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Bronchopneumonia OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH (A) Acute bronchitis and DUE TO (B) Bronchopneumonia DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
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19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .					
23A. SIGNATURE Stanley B. Durlacher M.D.		23B. CHIEF MEDICAL EXAMINER ASSISTANT MEDICAL EXAMINER		23C. DATE SIGNED Nov 26, 1950	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE II/28/1950		24C. NAME OF CEMETERY OR CREMATORY Mt Calvary Cem.	
24D. LOCATION (City, town, or county) Brooklyn Md		24E. FUNERAL DIRECTOR Elroy O. Wilson 1000 Blandly		24F. ADDRESS	

DATE RECEIVED BY LOCAL REGISTRAR Nov 27, 1950		REGISTRAR'S SIGNATURE Stanley B. Durlacher M.D.		25. FUNERAL DIRECTOR Elroy O. Wilson 1000 Blandly	
V S 151		107.0		✓	

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50-10143

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10143

Registered No. _____

1. NAME OF DECEASED (Type or Print) MARY B. RASKA			2. DATE OF DEATH Nov. 24-1950		
3. PLACE OF DEATH: A. Baltimore City, Maryland Balto. City			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY _____		
B. FULL NAME OF HOSPITAL OR INSTITUTION 4300 Curtis ave			C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township) Balto. City		
c. Length of stay in Baltimore 63 Yrs. Mths. Days			D. STREET ADDRESS (If rural, give location) 4300 Curtis ave		
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Feb. 15-1873		9. AGE (In years last birthday) 77
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Czechoslovakia		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Vaclaw Kosar			14. MOTHER'S MAIDEN NAME		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS Frank C. Schultz 4300 Curtis Ave		

18. Yr. 1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Edema of the lungs		CAUSE OF DEATH INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Decompensated heart failure		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION 0		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) no		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
TIME (Month) (Day) (Year) (Hour) Nov 24. 1950 4 PM		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Nov 1, 1950 , to Nov 24, 1950 , that I last saw the deceased alive on Nov 24, 1950 , and that death occurred at 4 PM m., from the causes and on the date stated above.					
23A. SIGNATURE Eugene Schnitzer		23B. ADDRESS 3804 S. Hanover		23C. DATE SIGNED Nov 25th	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE Nov. 28-1950		24C. NAME OF CEMETERY OR CREMATORY Holy Cross	
24D. LOCATION (City, town, or county) A.A. Co.		24E. LOCATION (City, town, or county) Md.		24F. LOCATION (City, town, or county) Md.	
DATE RECEIVED BY LOCAL REGISTRAR NOV 27 1950		REGISTRAR'S SIGNATURE Huntington Williams		25. FUNERAL DIRECTOR ADDRESS Wm. S. Fialkowski 2007 Eastern Ave	

30-101-3

RECEIVED
CENTRAL OFFICE OF INVESTIGATION
U.S. DEPARTMENT OF JUSTICE

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326

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10144

Registered No.

BIRTH NO. 10114

1. NAME OF DECEASED (Type or Print) <i>Catherine Heitzer</i>		2. DATE OF DEATH <i>11/26/50</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <i>Balto, Md.</i>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md</i> B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>South Balto General</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Balto Md 23 01</i>	
C. Length of stay in Baltimore Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) <i>1409 Olive St</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>S</i>	8. DATE OF BIRTH <i>Jan. 14 - 1895</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Packer</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Pickle Packing Co</i>	9. AGE (in years last birthday) <i>55</i>
11. BIRTHPLACE (State or foreign country) <i>Balto, Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>Joseph L. Heitzer</i>		14. MOTHER'S MAIDEN NAME <i>Catherine Wolf</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>317-07-3047</i>	
17. INFORMANT <i>Miss Annie Rener</i>		ADDRESS <i>1409 Olive St.</i>	

18. <i>420.1</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Coronary Artery Disease</i>		INTERVAL BETWEEN ONSET AND DEATH
(A) DUE TO		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		
(B) DUE TO		
(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that I took charge of the remains described above, held an <i>Inspection</i> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .					

23A. SIGNATURE <i>W. J. Fulewski</i>		23B. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> MEDICAL INVESTIGATOR <input checked="" type="checkbox"/>		23C. DATE SIGNED <i>11/26/50</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>11/29/1950</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Holy Cross</i>	
24D. LOCATION (City, town, or county) <i>A. A. C. Md.</i>		24E. FUNERAL DIRECTOR <i>Flynn & Fleming</i>		ADDRESS <i>1426 Light St</i>	
DATE RECEIVED BY LOCAL REGISTRAR <i>NOV 27 1950</i>		REGISTRAR'S SIGNATURE <i>Huntington Williams, M.D.</i>			

10-11-11

STATE OF NEW YORK

CERTIFICATE OF DEATH

Name of Deceased		Date of Death	
Place of Birth		Date of Birth	
Cause of Death		Place of Death	
Signature of Physician		Signature of Registrar	
Signature of Coroner		Signature of Medical Examiner	
Signature of Burial Officer		Signature of Cemetery Officer	
Signature of Undertaker		Signature of Funeral Home	
Signature of Family		Signature of Friends	
Signature of Church		Signature of Synagogue	
Signature of Other		Signature of Other	

352
50-10145BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50-10145

1. NAME OF DECEASED (Type or Print) <u>Carolina Catenese</u>			2. DATE OF DEATH <u>Nov. 23, 1950</u>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>		
B. FULL NAME OF HOSPITAL OR INSTITUTION <u>520 E. 35th St.</u>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <u>Baltimore</u>		
c. Length of stay in Baltimore <u>45 years</u>			D. STREET ADDRESS (If rural, give location) <u>520 E. 35th St.</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Dec. 1859</u>	9. AGE (In years last birthday) <u>91</u>	10. Under 1 Year Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -----		10B. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) <u>Italy</u>	
13. FATHER'S NAME <u>Joseph Rindone</u>			14. MOTHER'S MAIDEN NAME -----		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Miss Germalia Catenese</u>	
18. <u>334X</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>Generalized Arteriosclerosis 10 yrs. with Cerebral Sclerosis.</u>			INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs.</u>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>Fracture, Left Femur</u> <u>Arteriosclerotic Gangrene, Right Leg.</u>			CERTIFICATE APPROVED BY <u>William V. Gault</u> M.D. CHIEF OR ASST. MEDICAL EXAMINER		
19A. DATE OF OPERATION <u>Nov. 11 1950 10 A.M.</u>		19B. MAJOR FINDINGS OF OPERATION <u>Home</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) <u>Home</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Home</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>520 E. 35th St.</u>	
21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>Fell when slipped on floor.</u>			
22. I hereby certify that I attended the deceased from <u>Nov. 11</u> , 19 <u>50</u> , to <u>Nov. 23</u> , 19 <u>50</u> , that I last saw the deceased alive on <u>Nov. 23</u> , 19 <u>50</u> , and that death occurred at <u>3 P.M.</u> , from the causes and on the date stated above.					
23A. SIGNATURE <u>Wm. H. Kammer, Jr.</u>		23B. ADDRESS <u>501 Sheridan Ave.</u>		23C. DATE SIGNED <u>Nov. 25, 1950</u>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>11/27/50</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cem.</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>		25. FUNERAL DIRECTOR <u>John A. Moray</u> <u>3000 E. Baltimore St.</u>			

50-10112

RECORDS OF THE

1-11-1930



12-28-50

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10146

Registered No.

-600
50-10146
BIRTH NO1. NAME OF DECEASED
(Type or Print)

JOHN BARRY

2. DATE
OF
DEATH

11-25-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

Baltimore Md

B. FULL NAME OF
HOSPITAL OR
INSTITUTION

(If not in hospital or institution, give street address or location)

University Hosp

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

B. COUNTY

before admission)

Balt

Balt

MD Anne A

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Brooklyn

D. STREET ADDRESS (If rural, give location)

10 Ballman Court

c. Length of stay in Baltimore

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

M

8. DATE OF BIRTH

June 1922

9. AGE (In years
last birthday)

28 yr

If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of worklog life, even if retired)Brakeman
13. FATHER'S NAME

Keith Barry

10B. KIND OF BUSINESS OR
INDUSTRY

RR Railroad

11. BIRTHPLACE (State or foreign country)

Baltimore

12. CITIZEN OF
WHAT COUNTRY?

US

14. MOTHER'S MAIDEN NAME

Margaret M. Rogers

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.
212-18-9079

17. INFORMANT

ADDRESS

Annette Barry 10 Ballman Court.

18. 080.0

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A)

DUE TO

Polio myelitis

Bulbar
SpiralINTERVAL BETWEEN
ONSET AND DEATH

(over)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

Bronchitis pneumonia

(C)

CERTIFICATION APPROVED BY

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

CHIEF OR ASST. MEDICAL EXAMINER.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY

YES ☒ NO ☐21A. ACCIDENT WAS UNDER-
LYING OR CONTRIBUTING
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)

Railroad

21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

B+O R.R.

21D. TIME (Month) (Day) (Year) (Hour)
INJURY

Nov 11 1950 2AM

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

Rolling Boxcar

22. I hereby certify that I attended the deceased from Nov 20, 1950, to Nov 24, 1950, that I last saw the deceased alive on Nov 24, 1950, and that death occurred at 6 AM, from the causes and on the date stated above.

23A. SIGNATURE

M. D.

23B. ADDRESS

University Hosp

23C. DATE SIGNED

11-25-50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

Burial

11/28/50

Balto. Nat'l. Cem.

Baltimore

Md.

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

NOV 27 1950

Washington Williams, M.D.

John A. Moran

John A. Moran

3000 E. Balto.

VS 150

624 50

36

MEDICAL CERTIFICATION

as yet, no definite findings on cause of death 11/26

- Dr. Edith M. Stewart's case (joint ph.).
Letter to John Wagner to take to Dr. Fisher

in punching down of death cause detail.

Chief Medical Examiner,
Spoke to Dr. Fisher, over phone 1/8/1951 and

Dr. Fisher stated "this was a bulbar poliomyelitis death", also verified by Dr.

E. Steman

"diagnosis

John Wagner"

X

460
50-10147BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10147

Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED (Type or Print) Koehler, Clarence Frederick			2. DATE OF DEATH Nov. 25, 1950		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY _____		
B. FULL NAME OF HOSPITAL OR INSTITUTION St. Joseph's			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore		
c. Length of stay in Baltimore 56			D. STREET ADDRESS (If rural, give location) 1527 33d St.		
5. SEX M.	6. COLOR OR RACE W.	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH May 10, 1894	9. AGE (In years last birthday) 56	10. Under 1 Year Months: Days: 11. Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Proprietor			10B. KIND OF BUSINESS OR INDUSTRY Institution		
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland			12. CITIZEN OF WHAT COUNTRY? _____		
13. FATHER'S NAME Frederick C. Koehler			14. MOTHER'S MAIDEN NAME Mary Shields		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) _____			16. SOCIAL SECURITY NO. _____		
17. INFORMANT Mrs. Margaret F. Koehler			ADDRESS 1527 E. 33d St.		

18. 58111 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Cirrhosis of the liver DUE TO Chronic alcoholism DUE TO Chronic alcoholism DUE TO Chronic alcoholism			INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2			19B. MAJOR FINDINGS OF OPERATION		
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)			21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY			21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
21F. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from Nov. 23, 1950 to Nov. 25, 1950 , that I last saw the deceased alive on Nov. 25, 1950 , and that death occurred at 3:34p.m. , from the causes and on the date stated above.					
23A. SIGNATURE B. J. J. J.			23B. ADDRESS 1100 N. Caroline St.		
23C. DATE SIGNED Nov. 25, 1950					
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial			24B. DATE 11/28/50		
24C. NAME OF CEMETERY OR CREMATORY New Cathedral			24D. LOCATION (City, town, or county) (State) Baltimore, Md.		
DATE RECEIVED BY LOCAL REGISTRAR			REGISTRAR'S SIGNATURE Washington Williams, M.D.		
25. FUNERAL DIRECTOR W. H. Meekins			ADDRESS 124 a		

NOV 27 1950

29068

20050-10148

LOUIS PETE BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

50-10148

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Louis, Mr Pete

2. DATE
OF
DEATH

11-24-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, If institution: residence

A. STATE

B. COUNTY

before admission)

B. FULL NAME OF (If not in hospital or institution, give street address or
HOSPITAL OR location)
INSTITUTION Church Home HospitalC. CITY OR TOWN (If outside corporate limits, write RURAL and give
township)

Portsmouth

D. STREET ADDRESS (If rural, give location)

c. Length of stay in Baltimore

12 hr

Yrs.
Mos.
Days

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Divorced

8. DATE OF BIRTH

March 11 1894

9. AGE (In years
last birthday)

56

10. Under 1 Year
Months: Days11. Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Hotel keeper

10B. KIND OF BUSINESS OR
INDUSTRY

Rooming house

11. BIRTHPLACE (State or foreign country)

Greece

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

CAUSE OF DEATH

18. 5810

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A)

Cirrhosis of liver

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

Coronary occlusion

DUE TO

(C)

Arteriosclerosis

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.INTERVAL BETWEEN
ONSET AND DEATH

19A. DATE OF OPERATION

Nov 15 1950

19B. MAJOR FINDINGS OF OPERATION

Cirrhosis of liver

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov 8, 1950, to Nov 24, 1950; that I last saw the
deceased alive on Nov 24, 1950, and that death occurred at 2 P. m., from the causes and on the date stated above.

23A. SIGNATURE

Kirk Moore MD

M. D.

23B. ADDRESS

Church Home Hospital

23C. DATE SIGNED

Nov 24 1950

24A. (BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

11-28-

24C. NAME OF CEMETERY OR CREMATORY

Green Cemetery

24D. LOCATION (City, town, or county)

Windsor Mill Rd.

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

NOV 27 1950

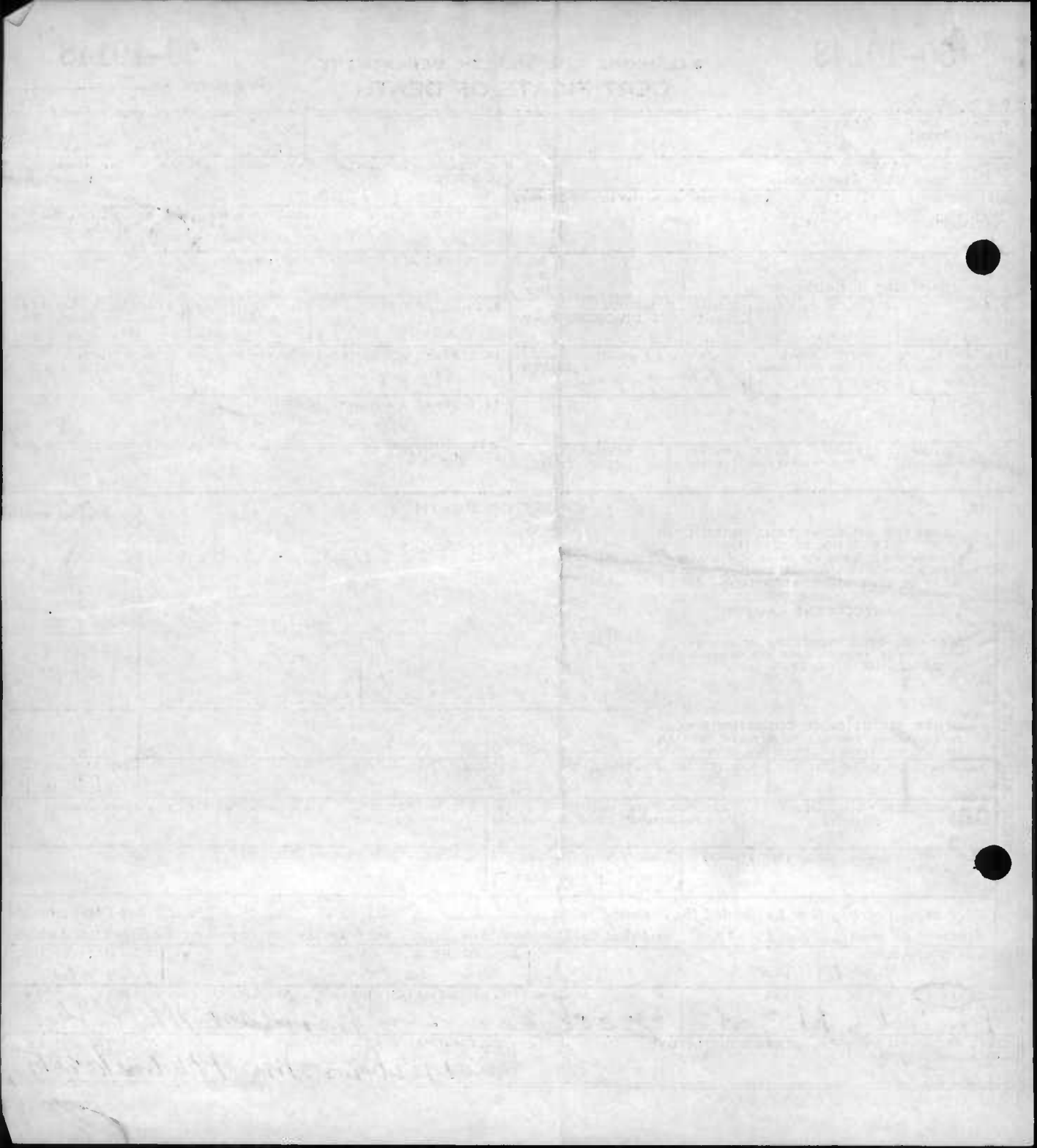
Lambert Inc 440 E. North

VS 150

25088

1246 over

MEDICAL CERTIFICATION



450
66101-05
50-10149

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10149
Registered No.

BIRTH NO.		1. NAME OF DECEASED (Type or Print) FALLIN, MARGARET HAZELTON		2. DATE OF DEATH 11/26/50	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE md. B. COUNTY			
B. FULL NAME OF HOSPITAL OR INSTITUTION Provident		C. CITY OR TOWN (If outside corporate limits, write full name and give township) Baltimore 15-02			
C. Length of stay in Baltimore 3.0 yrs		D. STREET ADDRESS (If rural, give location) 1330 Mount			
5. SEX Female	6. COLOR OR RACE Negro	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 5/6/11	9. AGE (In years, last birthday) 39	
10A. USUAL OCCUPATION (Give kind of work done during most of work log life, even if retired) at home		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Chester md		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Jermale Hazelton			14. MOTHER'S MAIDEN NAME Lottie Richards ✓		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT Wm. Fallin ADDRESS 1330 Mount		

MEDICAL CERTIFICATION

18. 410X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Rheumatic Heart Disease DUE TO		CAUSE OF DEATH Mitral insufficiency DUE TO	INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. (C)			

19A. DATE OF OPERATION 0		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?			

22. I hereby certify that I attended the deceased from **11/23, 1950** to **11/26, 1950** that I last saw the deceased alive on **11/26, 1950**, and that death occurred at **11 A. m.**, from the causes and on the date stated above.

23A. SIGNATURE John H. Holmes III M. D.	23B. ADDRESS Provident Hosp.	23C. DATE SIGNED 11/27/50
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24A. BURIAL, CREMATION, REMOVAL (Specify) Burial	24B. DATE Nov. 30-50	24C. NAME OF CEMETERY OR CREMATORY Chester	24D. LOCATION (City, town, or county) (State) md
DATE RECEIVED BY LOCAL REGISTRAR NOV 28 1950		REGISTRAR'S SIGNATURE James A. Hayes	25. FUNERAL DIRECTOR James A. Hayes ADDRESS 638 N. Belmor

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54
10-10150 Hospital Disposition

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10150
Registered No.

BIRTH NO. 50-24867

1. NAME OF DECEASED (Type or Print) **Baby Boy Cromwell**

2. DATE OF DEATH **Nov. 20, '50**

3. PLACE OF DEATH:
a. Baltimore City, Maryland **HH Penn**

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE **Ind.** b. COUNTY **Baltimore**

5. FULL NAME OF HOSPITAL OR INSTITUTION **JOHNS HOPKINS HOSPITAL**

6. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Balls.

7. STREET ADDRESS (If rural, give location)
625 L. Arundale Rd. 5300

8. DATE OF BIRTH **11-18-50**

9. AGE (in years last birthday) **7**

10. Length of stay in Baltimore
Yrs. **0** Mos. **0** Days **0**

11. BIRTHPLACE (State or foreign country) **Maryland**

12. CITIZEN OF WHAT COUNTRY? **?**

13. FATHER'S NAME **John Cromwell**

14. MOTHER'S MAIDEN NAME **Rosabelle**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) **No**

16. SOCIAL SECURITY NO. **JOHNS HOPKINS HOSPITAL**

17. INFORMANT ADDRESS **JOHNS HOPKINS HOSPITAL**

18. **776 X 1**
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) **Prematurity**
DUE TO (A) **Prematurity**

19. ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO (B)
(C)

20. OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

21. DATE OF OPERATION **2**

22. MAJOR FINDINGS OF OPERATION

23. AUTOPSY? **YES** ☒ **NO** ☐

24. ACCIDENT WAS UNDER-
LYING OR CONTRIBUTING CAUSE OF DEATH ☐

25. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

26. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

27. TIME (Month) (Day) (Year) (Hour) INJURY

28. INJURY OCCURRED

29. HOW DID INJURY OCCUR?

30. I hereby certify that I attended the deceased from **Nov. 13, 1950** to **Nov. 20, 1950** at I last saw the deceased alive on **Nov. 20, 1950** and that death occurred at **1:00** p.m., from the causes and on the date stated above.

31. SIGNATURE **Samuel J. Rosenberg** M. D.

32. ADDRESS **JOHNS HOPKINS HOSPITAL**

33. DATE SIGNED **11/20/50**

34. BURIAL, CREMA-
TION, REMOVAL (Specify)

35. DATE **NOV 28 1950**

36. NAME OF CEMETERY OR CREMATORY **Forest Burial**

37. LOCATION (City, town, or county) (State)

38. REGISTRAR'S SIGNATURE **William M. Williams**

39. FUNERAL DIRECTOR

40. ADDRESS

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Baby Boy Community

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FUNDERBURK
BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10151
Registered No.

1. NAME OF DECEASED (Type or Print) Baty Boy Funderburk		2. DATE OF DEATH Nov. 19, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland Red Hill Rd B. FULL NAME OF HOSPITAL OR INSTITUTION JOHNS HOPKINS HOSPITAL		4. USUAL RESIDENCE (Where deceased lived. If institution: residence) A. STATE Md B. COUNTY Baltimore	
5. SEX Male 6. COLOR OR RACE Colored 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Unwed		8. DATE OF BIRTH 11-17-1950 9. AGE (In years last birthday) 3 10 Under 1 Year Months: Days 11 Under 24 Hours Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Louise Funderburk		14. MOTHER'S MAIDEN NAME Ophelia Ingram	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT JOHNS HOPKINS HOSPITAL		ADDRESS	

18. 776 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Pneumonia DUE TO		INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION 0		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 11-17- , 19 50 to 11-19- , 19 50 that I last saw the deceased alive on 11-19- , 19 50 and that death occurred at 8:15 m., from the causes and on the date stated above.					
23A. SIGNATURE C. J. Kasper M. D.		23B. ADDRESS JOHNS HOPKINS HOSPITAL		23C. DATE SIGNED 11-19-50	
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY Hope Deaford	
24D. LOCATION (City, town, or county)		(State)			

DATE RECEIVED BY LOCAL REGISTRAR NOV 28 1950		REGISTRAR'S SIGNATURE Walter J. Williams, Md		25. FUNERAL DIRECTOR ADDRESS	
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BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50-10152

50-10152

1. NAME OF DECEASED (Type or Print) GIOVANNINA SCARDINA		2. DATE OF DEATH 11/27/50	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE MD. B. COUNTY	
5. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION ST. JOSEPH'S HOSP.		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTO.	
c. Length of stay in Baltimore Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) 3702 4th ST.	
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	B. DATE OF BIRTH March 13, 1892
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY At Home	9. AGE (In years, last birthday) 58
11. BIRTHPLACE (State or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Dominick Brocato		14. MOTHER'S MAIDEN NAME Josephine Ray	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT r. Dominic Scardina - 3702 - 4th St.		ADDRESS Brooklyn, Md.	

18. 2041 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Acute myelogenous leukemia	CAUSE OF DEATH (A) DUE TO	INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B) DUE TO	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	(C)	

19A. DATE OF OPERATION 0	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **10/19/50**, 19__, to **11/27/50**, 19__, that I last saw the deceased alive on **11/20/50**, and that death occurred at **12:55** a.m., from the causes and on the date stated above.

23A. SIGNATURE Maddens Siwinski M. D.	23B. ADDRESS St. Joseph's Hosp.	23C. DATE SIGNED 11/27/50
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24A. BURIAL, CREMATION, REMOVAL (Specify) Burial	24B. DATE 11/30/50	24C. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cem.	24D. LOCATION (City, town, or county) (State) Balto., Md.
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DATE RECEIVED BY LOCAL REGISTRAR NOV 28 1950	REGISTRAR'S SIGNATURE Anthony J. Williams, M.D.	25. FUNERAL DIRECTOR Wm. J. Dickener & Sons - Balt.	ADDRESS 0742 11th
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655
50-10153
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50-10153

1. NAME OF DECEASED (Type or Print) MARY LATCHFORD NURMENT		2. DATE OF DEATH Nov. 27, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION UNION MEMORIAL HOSPITAL		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE 10	
c. Length of stay in Baltimore Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) 4627 KESWICK RD.	
5. SEX F	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) W	8. DATE OF BIRTH MAY 5, 1880
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY At Home	9. AGE (in years last birthday) 70
13. FATHER'S NAME LEWIS E. LATCHFORD		11. BIRTHPLACE (State or foreign country) MARYLAND	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
16. SOCIAL SECURITY NO. no		14. MOTHER'S MAIDEN NAME MARGARET Snyder	
17. INFORMANT Miss Helen Latchford		ADDRESS 4627 Keswick Rd.	

18. 443X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Acute myocardial failure DUE TO (A) Acute myocardial failure (B) Hypertensive cardiovascular disease DUE TO (C) Hypertensive cardiovascular disease	CAUSE OF DEATH Acute myocardial failure Hypertensive cardiovascular disease	INTERVAL BETWEEN ONSET AND DEATH
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION 0		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED m. WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Nov. 24 , 19 50 , to Nov. 27 , 19 50 , that I last saw the deceased alive on Nov. 27 , 19 50 , and that death occurred at 1:50 A.M. , from the causes and on the date stated above.					
23A. SIGNATURE Alfred S. Nelson		23B. ADDRESS Union Memorial Hospital Baltimore 18 Maryland		23C. DATE SIGNED Nov 27, 1950	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/28/50		24C. NAME OF CEMETERY OR CREMATORY Druid Ridge Cem.	
24D. LOCATION (City, town, or county) Pikesville, Md.		24E. DATE RECEIVED BY LOCAL REGISTRAR NOV 28 1950		24F. REGISTRAR'S SIGNATURE Wm. J. Williams	
24G. DATE RECEIVED BY LOCAL REGISTRAR NOV 28 1950		24H. REGISTRAR'S SIGNATURE Wm. J. Williams		24I. FUNERAL DIRECTOR Wm. J. Williams & Sons - Balto Md.	

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50-10154

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50-10154

1. NAME OF DECEASED (Type or Print) FRANK L. HOFFMAN		2. DATE OF DEATH November 26, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore	
B. FULL NAME OF (If not in hospital or institution, give street address or location) Union Memorial Hospital		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore	
C. Length of stay in Baltimore		D. STREET ADDRESS (If rural, give location) 1074 Cameron Road - 12	
5. SEX male	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH Feb. 5, 1923
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic		10B. KIND OF BUSINESS OR INDUSTRY Auto. Repair	9. AGE (In years last birthday) 27
13. FATHER'S NAME William A. Hoffman		11. BIRTHPLACE (State or foreign country) Iowa	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) yes World War II		12. CITIZEN OF WHAT COUNTRY? WHAT COUNTRY?	
16. SOCIAL SECURITY NO. 483-12-6618		14. MOTHER'S MAIDEN NAME Ida Bouma	
17. INFORMANT Mrs. Ida Hoffman		ADDRESS - 1074 Cameron Rd.	

18. E816.4 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Fractured skull DUE TO Antecedent Causes DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Extradural and subdural hemorrhage DUE TO OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		INTERVAL BETWEEN ONSET AND DEATH
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19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) street	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Greenspring Ave. south of Woodland Ave.		29/16
21D. TIME (Month) (Day) (Year) (Hour) November 23, 1950 3.10pm.	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21F. HOW DID INJURY OCCUR? Auto and auto collision		

22. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE <i>William V. ...</i>		23B. CHIEF MEDICAL EXAMINER..... ASSISTANT MEDICAL EXAMINER..... M.D. MEDICAL INVESTIGATOR.....		23C. DATE SIGNED Nov. 27, 1950
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial	24B. DATE 11/29/50	24C. NAME OF CEMETERY OR CREMATORY Balto. National Cem.	24D. LOCATION (City, town, or county) (State) Balto., Md.	

DATE RECEIVED BY LOCAL REGISTRAR NOV 28 1950	REGISTRAR'S SIGNATURE <i>William V. ...</i>	25. FUNERAL DIRECTOR <i>Wm. J. ...</i>	ADDRESS <i>Caro Balt.</i>
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MEDICAL CERTIFICATION

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50-10155
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10155
Registered No.

1. NAME OF DECEASED (Type or Print)		ANNA ESTELLA NEUBAUER		2. DATE OF DEATH November 27, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION 1662 Gorsuch Avenue				C. CITY OR TOWN (If outside corporate limits, write rural and give township) Baltimore	
c. Length of stay in Baltimore				D. STREET ADDRESS (If rural, give location) 1662 Gorsuch Avenue	
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) single	8. DATE OF BIRTH Sept. 29, 1887	9. AGE (In years last birthday) 63	10. Under 1 Year Months: Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk			11. BIRTHPLACE (State or foreign country) Balto., Md.		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Nicholas Neubauer			14. MOTHER'S MAIDEN NAME Louise Klank		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no			16. SOCIAL SECURITY NO.		
17. INFORMANT			ADDRESS Mr. John J. Neubauer - 210 Cedarcroft Rd		

18. 443X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Hypertensive cardiovascular disease		INTERVAL BETWEEN ONSET AND DEATH
(A) DUE TO		
ANTECEDENT CAUSES		
(B) DUE TO		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		
(C) DUE TO		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	

22. I certify that I took charge of the remains described above, held an Insp. & Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE <i>William J. Sienkiewicz</i>		23B. CHIEF MEDICAL EXAMINER..... M.D. ASSISTANT MEDICAL EXAMINER..... MEDICAL INVESTIGATOR.....		23C. DATE SIGNED 11-27-50	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial	24B. DATE 11/30/50	24C. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cem.	24D. LOCATION (City, town, or county) (State) Balto., Md.		
DATE RECEIVED BY LOCAL REGISTRAR NOV 28 1950	REGISTRAR'S SIGNATURE <i>William J. Sienkiewicz</i>	25. FUNERAL DIRECTOR <i>Wm. J. Sienkiewicz & Sons - Balto</i>		ADDRESS 093d Md	

530
50-10156
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10156
Registered No.

1. NAME OF DECEASED (Type or Print) FREDERICK C. SCHMIDT, Jr.		2. DATE OF DEATH November 27, 1950	
3. PLACE OF DEATH: a. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) a. STATE Maryland b. COUNTY 17-03	
b. FULL NAME OF HOSPITAL OR INSTITUTION Franklin Square Hospital		c. CITY OR TOWN (If outside corporate limits, give RURAL and give township) Baltimore	
c. Length of stay in Baltimore		d. STREET ADDRESS (If rural, give location) 19 S. Calhoun Street	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH June 7, 1913
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seaman 1/C		10b. KIND OF BUSINESS OR INDUSTRY Merchant Marine	9. AGE (In years last birthday) 37
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? 17-03	
13. FATHER'S NAME Frederick C. Schmidt, Sr.		14. MOTHER'S MAIDEN NAME Floretta Arleane	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. J. S. Foxwell		ADDRESS - 222 Laurens St.	

18. 5-81-0 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Cirrhosis of liver DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH (A) Cirrhosis of liver DUE TO (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH
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19a. DATE OF OPERATION 11/28/50		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Insp. & Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

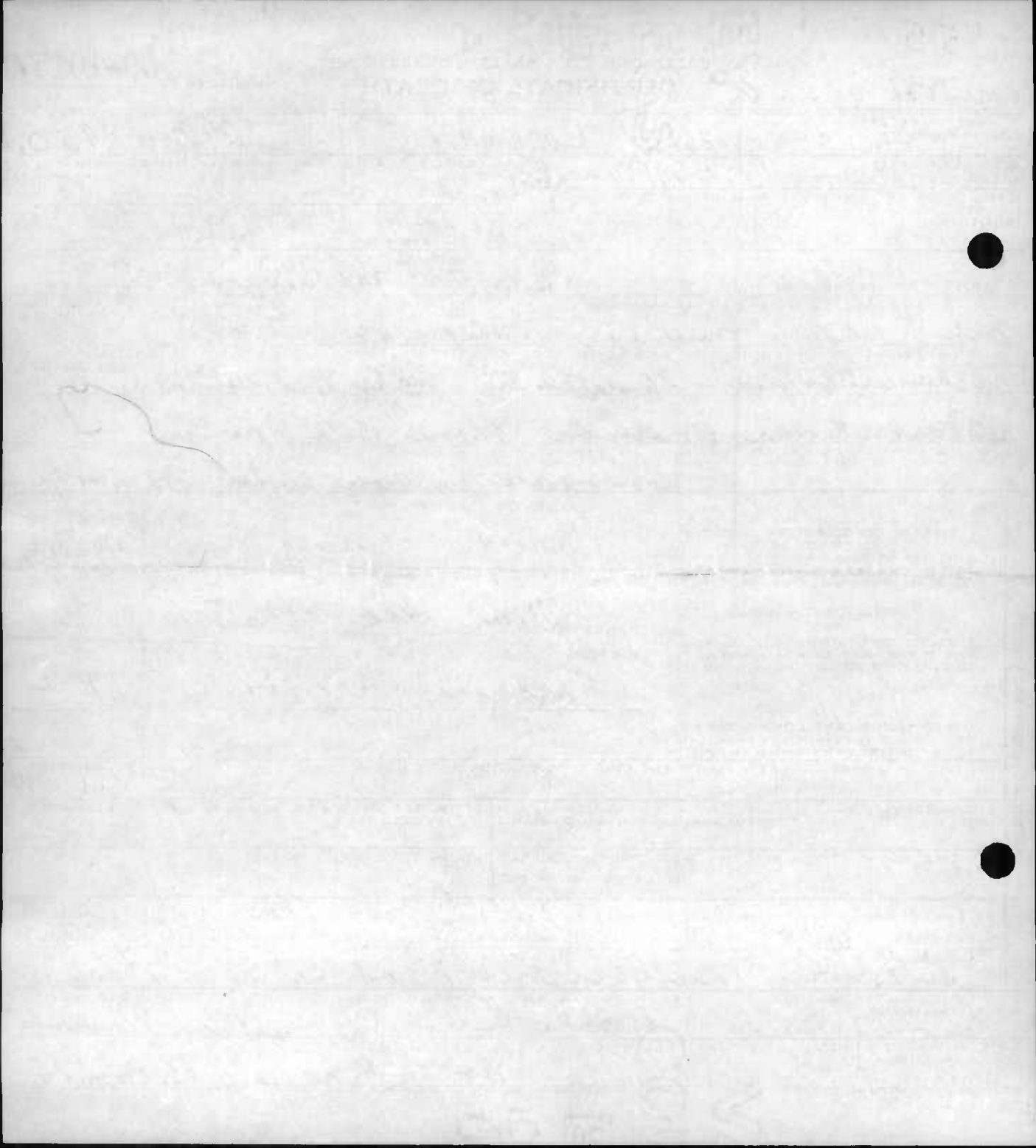
23a. SIGNATURE <i>William V. Lovett</i>		23b. CHIEF MEDICAL EXAMINER..... <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER..... <input checked="" type="checkbox"/> M.D. MEDICAL INVESTIGATOR..... <input type="checkbox"/>		23c. DATE SIGNED 11-27-50
24a. BURIAL, CREMATION, REMOVAL (Specify) Interment	24b. DATE 11/28/50	24c. NAME OF CEMETERY OR CREMATORY Druid Ridge Maus.	24d. LOCATION (City, town, or county) (State) Pikesville, Md.	
DATE RECEIVED BY LOCAL REGISTRAR NOV 28 1950		REGISTRAR'S SIGNATURE <i>William V. Lovett</i>		25. FUNERAL DIRECTOR <i>Wm. J. Tichenor</i>

BIRTH-NO

1. NAME OF DECEASED (Type or Print) GEORGE WESLEY CUSHMAN		2. DATE OF DEATH 27 Nov. 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland 15 W. Mt Vernon Pl		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE md. B. COUNTY 11-00	
5. FULL NAME OF HOSPITAL OR INSTITUTION		C. CITY OR TOWN (If outside corporate limits, write R.U.H. and give township) Baltimore	
c. Length of stay in Baltimore		D. STREET ADDRESS (If rural, give location) 15 W. Mt. Vernon Place	
5. SEX Male	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH March 11, 1881
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanical Engineer - General Electric		9. AGE (In years last birthday) 69	
10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Waterford, Vermont	
13. FATHER'S NAME Charles E. & Mrs. Cushman		12. CITIZEN OF WHAT COUNTRY? ELEC. APPL. MATHS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		14. MOTHER'S MAIDEN NAME Flora Bell Fowler	
16. SOCIAL SECURITY NO. 009-09-85044		17. INFORMANT ADDRESS Mrs. George Cushman, 15 W. Mt. Vernon Pl	
18. 420.1 I 163X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Cancer of Lung ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Cardiac Decompensation OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Coronary Thrombosis		INTERVAL BETWEEN ONSET AND DEATH 3 Months 7 Yrs	
19A. DATE OF OPERATION 0		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 1 Sept. 1950 to 27 Nov. 1950 , that I last saw the deceased alive on 25 Nov. 1950 , and that death occurred at 8:40 A.M. , from the causes and on the date stated above.			
23A. SIGNATURE S. Edwin Muller		23B. ADDRESS 2 W. Reed St	
23C. DATE SIGNED 27 Nov. 1950			
24A. BURIAL, CREMATION, REMOVAL (Specify) Removal		24B. DATE 11/28/50	
24C. NAME OF CEMETERY OR CREMATORY St. Johnsbury		24D. LOCATION (City, town, or county) (State) St. Johnsbury, Vermont	
DATE RECEIVED BY LOCAL REGISTRAR NOV 28 1950		REGISTRAR'S SIGNATURE William H. Williams	
25. FUNERAL DIRECTOR Wm. Cook, Inc.		ADDRESS 1017 St. Paul St.	

04634

047d



520
50-10158
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10158
Registered No.

1. NAME OF DECEASED (Type or Print) JOHN COTTRELL YOUNG			2. DATE OF DEATH 27 Nov. 1950		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Balt.		
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTE Union Memorial Hospital			C. CITY OR TOWN (If outside corporate limits, write FULL and give township) Baltimore #11 12-06		
c. Length of stay in Baltimore Yrs. Mos. Days			D. STREET ADDRESS (If rural, give location) 206 W. 27th St.		
5. SEX M	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 18 Feb. 1905		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Painter			9. AGE (In years last birthday) 45		
10B. KIND OF BUSINESS OR INDUSTRY CONST			11. BIRTHPLACE (State or foreign country) Ashland, Maine		
13. FATHER'S NAME Harry Young			12. CITIZEN OF WHAT COUNTRY? U. S. A.		
15. WAS DECEASED EVER IN U. S. ARMED FORCES (If yes, give war or dates of service) Unknown			16. SOCIAL SECURITY NO. 230-05-3590		
17. INFORMANT Patience			ADDRESS		

18. 202.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) RETICULO-ENDOTHELIOSIS (GENERALIZED)		INTERVAL BETWEEN ONSET AND DEATH ?
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION 2		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 18 Nov. , 1950, to 27 Nov. , 1950, that I last saw the deceased alive on 27 Nov. , 1950, and that death occurred at 5:25 A.M. , from the causes and on the date stated above.					
23A. SIGNATURE Richard Beach		23B. ADDRESS M. O. Union Memorial Hospital		23C. DATE SIGNED 11/27/50	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/30/50		24C. NAME OF CEMETERY OR CREMATORY Meadow Ridge	
24D. LOCATION (City, town, or county) (State) Dorsey Md.		DATE RECEIVED BY LOCAL REGISTRAR NOV 28 1950			
REGISTRAR'S SIGNATURE Wm. J. Williams, M.D.		25. FUNERAL DIRECTOR Wm. Cook Inc. 1217 St. Paul St.			

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50-10159
BIRTH NO.BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

X Registered No. 50-10159

1. NAME OF DECEASED (Type or Print) <i>Joseph Miller</i>			2. DATE OF DEATH <i>11/26/50</i>		
3. PLACE OF DEATH: A. Baltimore City, Maryland <i>Baltimore, Maryland</i>			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Anne Arundel</i>		
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>South Baltimore General Hospital</i>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Diveria Beach - RIVIERA</i>		
C. Length of stay in Baltimore			D. STREET ADDRESS (If rural, give location) <i>Rural 5200</i>		
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Widowed</i>	8. DATE OF BIRTH <i>11/13/1870</i>		9. AGE (In years last birthday) <i>80</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>			10B. KIND OF BUSINESS OR INDUSTRY <i>Copierage</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>
13. FATHER'S NAME <i>Henry Miller, Jr.</i>			12. CITIZEN OF WHAT COUNTRY? <i>Maryland</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>No</i>			16. SOCIAL SECURITY NO. <i>308 Rossiter Ave</i>		
18. <i>443 X</i> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Cerebro Vascular Hemorrhage 14 hrs</i>			INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <i>Hypertensive cardio vascular many years</i>			DUE TO (B) <i>disease</i>		
			DUE TO (C) <i>Arteriosclerosis many years</i>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>2</i>		19B. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>11/26/50</i> , 19__, to <i>11/26/50</i> , 19__, that I last saw the deceased alive on <i>11/26/50</i> , 19__, and that death occurred at <i>6 P.</i> m., from the causes and on the date stated above.					
23A. SIGNATURE <i>Agustin del Campo</i>		23B. ADDRESS <i>1213 light Street</i>		23C. DATE SIGNED <i>11/27/50</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>11/29/50</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Holy Redeemer</i>	
24D. LOCATION (City, town, or county) (State) <i>Balto. Md.</i>		DATE RECEIVED BY LOCAL REGISTRAR <i>NOV 28 1950</i>		REGISTRAR'S SIGNATURE <i>Wm. Cook Inc.</i>	
24E. FUNERAL DIRECTOR <i>Wm. Cook Inc.</i>		24F. ADDRESS <i>1217 St. Paul St.</i>			

10-10-53

10-10-53

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**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

Registered No. **59-10160**

BIRTH NO. 420 59-10160		1. NAME OF DECEASED (Type or Print) GEORGE ELLIS		2. DATE OF DEATH November 27, 1950	
3. PLACE OF DEATH: a. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE md b. COUNTY		
b. FULL NAME OF HOSPITAL OR INSTITUTION 1023 Hollins Street			c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore		
c. Length of stay in Baltimore			d. STREET ADDRESS (If rural, give location) 367 Maryland Rd.		
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Nov 5 - 1899	9. AGE (In years last birthday) 51	10. Under 1 Year Months: Days: 11. Under 24 Hours Hours: Min.
10a. USUAL OCCUPATION (Give kind of work done during part of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Balto md	
13. FATHER'S NAME August Ellis			14. MOTHER'S MAIDEN NAME Frances Felling		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. ?		17. INFORMANT ADDRESS Aileen Kimball 367 Maryland Rd	

18. 3220 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Acute alcoholism		INTERVAL BETWEEN ONSET AND DEATH
(A) DUE TO Acute alcoholism		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19a. DATE OF OPERATION 0		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	

22. I certify that I took charge of the remains described above, held an Insp. & Inquiry thereon and from Autopsy, Inspection or Inquiry the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23a. SIGNATURE <i>William V. Smith</i>		23b. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> M.D. MEDICAL INVESTIGATOR <input type="checkbox"/>		23c. DATE SIGNED 11-27-50	
24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE Nov 29-50	24c. NAME OF CEMETERY OR CREMATORY Western Cem	24d. LOCATION (City, town, or county) (State) Balto md		
DATE RECEIVED BY LOCAL REGISTRAR NOV 28 1950		REGISTRAR'S SIGNATURE <i>Wm. V. Smith</i>		25. FUNERAL DIRECTOR <i>Wm. V. Smith</i>	

03-1-1960

CHURCH OF CHRIST

03-1-1960

NAME		DATE	
FATHER		MOTHER	
BIRTH		DEATH	
AGE		SEX	
RELIGION		EDUCATION	
OCCUPATION		MARRIAGE	
CHILDREN		Siblings	
Notes		Remarks	

360
0-10161BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50-10161

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <i>Florence E. Fader</i>		2. DATE OF DEATH <i>Nov. 26/1950</i>	
3. PLACE OF DEATH: a. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>8-01</i>	
b. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <i>2103 Belair Rd.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore</i>	
c. Length of stay in Baltimore		d. STREET ADDRESS (If rural, give location) <i>2103 Belair Rd.</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Widow</i>	8. DATE OF BIRTH <i>Oct. 3-1882</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housework</i>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (in years, last birthday) <i>68</i>
13. FATHER'S NAME <i>John Vogler</i>		11. BIRTHPLACE (State or foreign country) <i>Balto. Md.</i>	
12. CITIZEN OF WHAT COUNTRY?		14. MOTHER'S MAIDEN NAME <i>Annie Henschaefer</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Minnie Jarleton</i>		ADDRESS <i>2103 Belair Rd.</i>	

18. <i>420.1</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH
(A) <i>Cranial occlusion</i>		DUE TO		<i>3 hrs.</i>
ANTECEDENT CAUSES		(B) <i>Hypertensive Cardio-vascular Disease</i>		<i>?</i>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		DUE TO		
(C) <i>Essential Hypertension</i>				<i>?</i>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				

19a. DATE OF OPERATION <i>0</i>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21d. TIME (Month) (Day) (Year) (Hour) INJURY	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from <i>August 22, 1945</i> , to <i>Nov 26</i> , 19 <i>50</i> , that I last saw the deceased alive on <i>Nov. 4</i> , 19 <i>50</i> , and that death occurred at <i>1 A.</i> m., from the causes and on the date stated above.				
23a. SIGNATURE <i>Leland Brill</i>		23b. ADDRESS M. D. <i>1221 N. Luzum Ave</i>		23c. DATE SIGNED <i>Nov. 27, 1950</i>
24a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	24b. DATE <i>Nov. 29-50</i>	24c. NAME OF CEMETERY OR CREMATORY <i>Balto. Cemetery</i>	24d. LOCATION (City, town, or county) <i>Balto. Md.</i>	
DATE RECEIVED BY LOCAL REGISTRAR <i>NOV 28 1950</i>	REGISTRAR'S SIGNATURE <i>Walter J. Williams, M.D.</i>	25. FUNERAL DIRECTOR <i>John H. Miller</i> ADDRESS <i>2334 Jefferson St.</i>		

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50-10162

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10162
Registered No.

1. NAME OF DECEASED (Type or Print) Grace Constance		2. DATE OF DEATH 11/26/50	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 9-05	
B. FULL NAME OF HOSPITAL OR INSTITUTION Maryland General Hospital		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore	
c. Length of stay in Baltimore 57 Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) 723 Gonsuch Ave #18	
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH 7-14-'93
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 57 If Under 1 Year Months: Days: If Under 24 Hours Hours: Min.
13. FATHER'S NAME JOHN L. SKILLMAN		11. BIRTHPLACE (State or foreign country) Maryland	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		12. CITIZEN OF WHAT COUNTRY? USA.	
16. SOCIAL SECURITY NO.		14. MOTHER'S MAIDEN NAME BLANCHE L. JEFFERS	
17. INFORMANT Mrs Chas. Borcherting		ADDRESS 1650 Northwick Court	

18. 443X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Acute pulmonary edema DUE TO (A) Acute pulmonary edema ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Hypertensive cardiovascular disease DUE TO (B) Hypertensive cardiovascular disease (C) OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	CAUSE OF DEATH INTERVAL BETWEEN ONSET AND DEATH
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19A. DATE OF OPERATION 0		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 11-26-1950 , to 11-26-1950 , that I last saw the deceased alive on 11-26-1950 , and that death occurred at 6:30 p.m., from the causes and on the date stated above.					
23A. SIGNATURE Marguerite Louise Cadotte M. D.		23B. ADDRESS Maryland General Hospital		23C. DATE SIGNED 11-26-50	
24A. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24B. DATE Nov. 29, 1950		24C. NAME OF CEMETERY OR CREMATORY COKEBURY METHODIST	
24D. LOCATION (City, town, or county) ABINGDON		24E. (State) MD.		25. FUNERAL DIRECTOR Henry H. Jenkins	
DATE RECEIVED BY LOCAL REGISTRAR NOV 28 1950		REGISTRAR'S SIGNATURE Washington, Md.		ADDRESS 4905 York Rd	

093d

1. The first part of the report is a general description of the project and its objectives. It includes a brief history of the project and a statement of the problem to be solved. The second part of the report is a detailed description of the methodology used in the study. This includes a description of the data collection methods, the statistical methods used to analyze the data, and the results of the analysis. The third part of the report is a discussion of the results of the study and their implications. This includes a comparison of the results with previous studies and a discussion of the limitations of the study. The final part of the report is a conclusion and a list of references.

2. The first part of the report is a general description of the project and its objectives. It includes a brief history of the project and a statement of the problem to be solved. The second part of the report is a detailed description of the methodology used in the study. This includes a description of the data collection methods, the statistical methods used to analyze the data, and the results of the analysis. The third part of the report is a discussion of the results of the study and their implications. This includes a comparison of the results with previous studies and a discussion of the limitations of the study. The final part of the report is a conclusion and a list of references.

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625

LC
512092
50-10163BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10163

Registered No.

1. NAME OF DECEASED (Type or Print) Mary Trischmann		2. DATE OF DEATH Nov 27, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore	
B. FULL NAME OF (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Avenue		C. CITY OR TOWN (If outside corporate limits, write R.U.M., and give township) Baltimore	
c. Length of stay in Baltimore Life		D. STREET ADDRESS (If rural, give location) 1306 Baylis Street	
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Jan. 13, 1866
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 84
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Jacob Conrad (D)		14. MOTHER'S MAIDEN NAME Mary E. ? (D)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Baltimore City Hospitals Records. 4940 Eastern Avenue		ADDRESS	
18. E900.0 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Bronchial Pneumonia DUE TO		INTERVAL BETWEEN ONSET AND DEATH ?	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Fracture Right Femur DUE TO Generalized Arteriosclerosis (C)		10-15 Yrs?	
CERTIFICATION APPROVED BY <i>[Signature]</i>			
19A. DATE OF OPERATION Nov 6, 1950		19B. MAJOR FINDINGS OF OPERATION Intertrochanteric front right hip	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		CHIEF OR ASST. MEDICAL EXAMINER.	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) At Home	
21C. WHERE DID INJURY OCCUR? 1306 Baylis Street.		21D. TIME (Month) (Day) (Year) (Hour) (Minute) (Second) 11-3-50 9:00 AM	
21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? Fell down stairs at home	
22. I hereby certify that I attended the deceased from Nov 13 , 1950, to Nov 27 , 1950 that I last saw the deceased alive on Nov 27 , 1950 and that death occurred at 10:45 AM , from the causes and on the date stated above.			
23A. SIGNATURE <i>[Signature]</i> M. D.		23B. ADDRESS 4940 Eastern Avenue	
23C. DATE SIGNED 11-27-50			
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/30/50	
24C. NAME OF CEMETERY OR CREMATORY Not Cared		24D. LOCATION (City, town, or county) (State)	
DATE RECEIVED BY LOCAL REGISTRAR NOV 28 1950		REGISTRAR'S SIGNATURE <i>[Signature]</i>	
25. FUNERAL DIRECTOR <i>[Signature]</i>		ADDRESS 2004 Calumet	

VS 150

N-821.0

TO BE APPROVED BY THE MEDICAL EXAMINER

1862

MEDICAL CERTIFICATE

635

BARTENFELDER

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50-10164

Registered No.

50-10164

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Mary E. Bartenfelder

2. DATE
OF
DEATH

11/27/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived before admission)
A. STATE B. COUNTY

Maryland Baltimore

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

Maryland General Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

6330 Hamilton Ave #6

c. Length of stay in Baltimore

Yrs.
Mos.
Days
9

5. SEX

Female

6. COLOR OR RACE

white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

widowed

8. DATE OF BIRTH

9-20-1884

9. AGE (In years last birthday)

66

10. Under 1 Year Months Days

11. Under 24 Hours Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Chas. A. Freund

14. MOTHER'S MAIDEN NAME

Mary. Hermann

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

None

17. INFORMANT

Elizabeth Bartenfelder

ADDRESS

as above

18.

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

Uremia

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

Chronic nephritis

DUE TO

(C)

Hypertensive Cardiovascular renal disease

INTERVAL BETWEEN ONSET AND DEATH

P

P

P

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11-18-1950 to 11-27-1950, that I last saw the deceased alive on 11-15-1950, and that death occurred at 330 p.m., from the causes and on the date stated above.

23A. SIGNATURE

Marguerite Louise Candless

23B. ADDRESS

Maryland General Hospital

23C. DATE SIGNED

11/27/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

12/1/50

24C. NAME OF CEMETERY OR CREMATORY

Zion Lutheran Cem.

24D. LOCATION (City, town, or county)

Baltimore Co Md

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

William Williams, Jr.

25. FUNERAL DIRECTOR

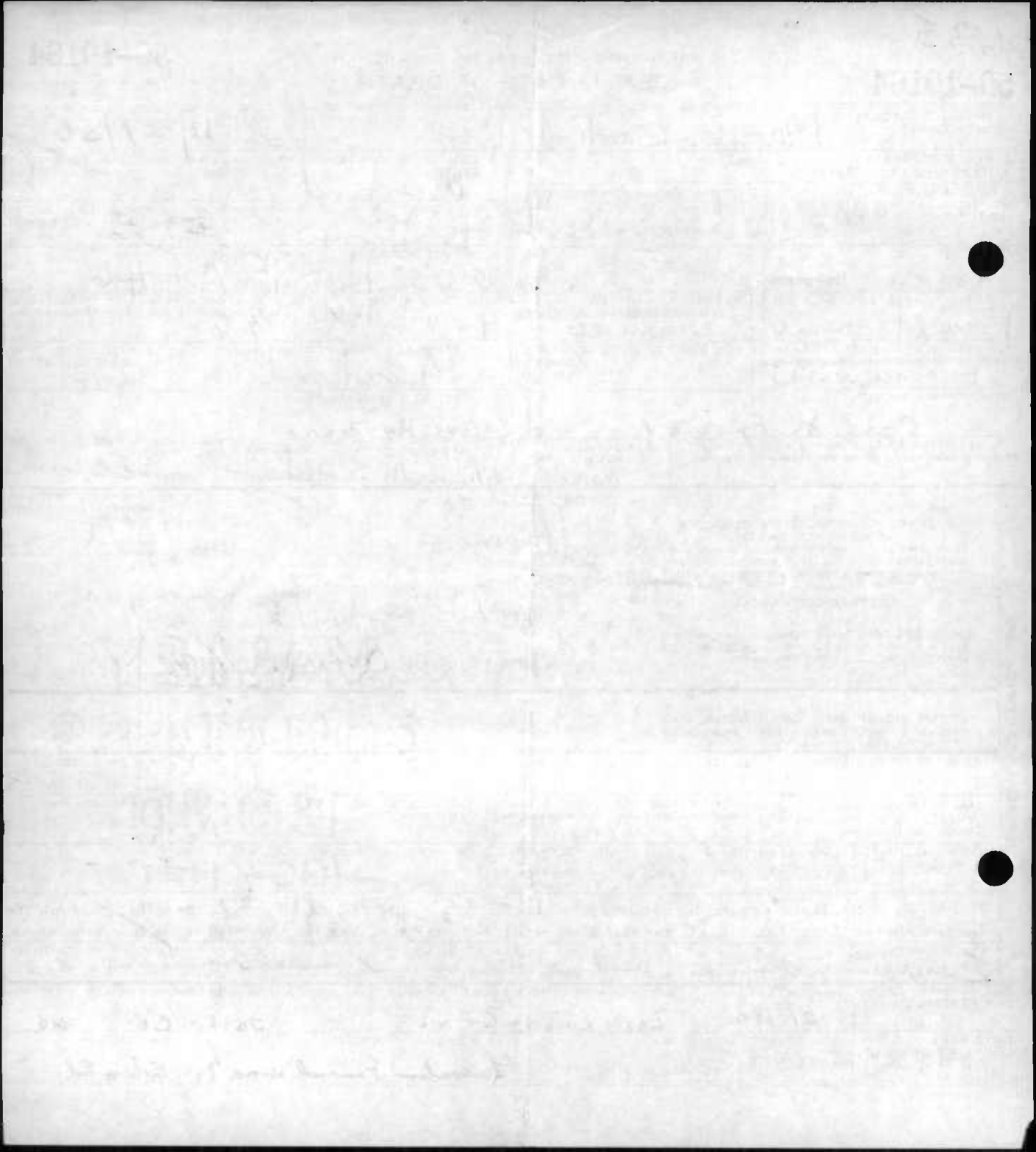
ADDRESS

Lassalle Funeral Home 7401 Belair Rd.

VS 150

1312

MEDICAL CERTIFICATION



236

50-10165

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50-10165

BIRTH NO.

1. NAME OF DECEASED (Type or Print) BOYD BAXTER			2. DATE OF DEATH Nov. 27, 1950		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY		
B. FULL NAME OF HOSPITAL OR INSTITUTION US Marine Hospital Wyman Pk. Drive & 31st St.			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore		
c. Length of stay in Baltimore ?			D. STREET ADDRESS (If rural, give location) 1602 Mc Cullough St.		
5. SEX M	6. COLOR OR RACE col	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 11/8/04		9. AGE (In years last birthday) 46
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer			11. BIRTHPLACE (State or foreign country) SC		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Stable Baxter			14. MOTHER'S MAIDEN NAME ?		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) ?		16. SOCIAL SECURITY NO. ?	17. INFORMANT ADDRESS Records - US Marine Hospital, Balto, Md.		

18. 2000 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Reticulum cell sarcoma (A) DUE TO		INTERVAL BETWEEN ONSET AND DEATH More than 1 yr.
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. (C)		

19A. DATE OF OPERATION 2	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **Oct. 9, 1950**, to **Nov. 26, 1950** that I last saw the deceased alive on **Nov. 26, 1950**, and that death occurred at **6:45A m.**, from the causes and on the date stated above.

23A. SIGNATURE **D.W. Patrick, Medical Officer in Charge**

23B. ADDRESS **US Marine Hospital, Balto, Md.**

23C. DATE SIGNED **11/27/50**

24A. BURIAL, CREMATION, REMOVAL (Specify) Removal	24B. DATE Nov 28 - 50	24C. NAME OF CEMETERY OR CREMATORY Washington, D.C.	24D. LOCATION (City, town, or county) (State) Washington, D.C.
DATE RECEIVED BY LOCAL REGISTRAR NOV 28 1950	REGISTRAR'S SIGNATURE Ernest Jarvis	25. FUNERAL DIRECTOR ADDRESS Ernest Jarvis Co 1432 8th St	

50-1083

CERTIFICATE OF DEATH

1965

John Barte

John Barte
1000 1st Ave
St. Paul, Minn 55101

200
50-10166BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50-10166

1. NAME OF DECEASED (Type or Print) <i>George Edward Diggs</i> <i>George DIGGS</i>		2. DATE OF DEATH <i>Nov 26 1950</i>	
3. PLACE OF DEATH: a. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <i>MD</i> b. COUNTY <i>6-05</i>	
b. FULL NAME OF (If not in hospital or institution, give street address or location) <i>Johns Hopkins Hosp.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore</i>	
c. Length of stay in Baltimore <i>Life</i>		d. STREET ADDRESS (If rural, give location) <i>203 Dallas Court</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Col.</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Single</i>	8. DATE OF BIRTH <i>Aug. 8, 1930</i>
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <i>Porter</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Real's Drug Co.</i>	9. AGE (In years last birthday) <i>20</i>
11. BIRTHPLACE (State or foreign country) <i>Baltimore Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>George Diggs</i>		14. MOTHER'S MAIDEN NAME <i>Unnie Rose Diggs</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <i>No.</i>		16. SOCIAL SECURITY NO. <i>216-20-5188</i>	
17. INFORMANT <i>George Diggs</i>		ADDRESS <i>516 Piquith St</i>	
18. <i>E981 X 1</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Bullet wound of back</i>		CAUSE OF DEATH <i>Bullet wound of back</i>	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <i>II</i> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION <i>2</i>		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/> UNDERLYING <input type="checkbox"/> CONTRIBUTING		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>street</i>	
21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <i>In front of 1106 Orleans Street</i>		21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <i>November 25, 1950 11 p.m.</i>	
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <i>firearms</i>	
22. I certify that I took charge of the remains described above, held an <i>Autopsy</i> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry , find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input checked="" type="checkbox"/> , undetermined <input type="checkbox"/> .			
23a. SIGNATURE <i>Stanley H. Dunclache M.D.</i>		23b. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> MEDICAL INVESTIGATOR <input type="checkbox"/>	
23c. DATE SIGNED <i>Nov. 26, 1950</i>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24b. DATE <i>11/30/50</i>	
24c. NAME OF CEMETERY OR CREMATORY <i>Mt. Calvary</i>		24d. LOCATION (City, town, or county) (State) <i>Anne Arundel Co. Md</i>	
25. FUNERAL DIRECTOR <i>Robert H. Young</i>		ADDRESS <i>1532 E. Monument St</i>	
DATE RECEIVED BY LOCAL REGISTRAR <i>NOV 28 1950</i>		REGISTRAR'S SIGNATURE <i>Antony J. Williams, M.D.</i>	

N-876.4

7806L

166.0

90-1156

MINNESOTA CIVIL SERVICE COMMISSION

CERTIFICATE OF DEATH

90-1156

DEATH OF

NAME OF DECEASED
DATE OF DEATH
PLACE OF DEATH
CAUSE OF DEATH

DATE OF BIRTH
PLACE OF BIRTH
OCCUPATION
MARRIAGE

EDUCATION
RELIGION
RACE
SEX

DATE OF DEATH
PLACE OF DEATH
CAUSE OF DEATH

DATE OF BIRTH
PLACE OF BIRTH
OCCUPATION

MARRIAGE
EDUCATION
RELIGION

RACE
SEX
DATE OF DEATH

415

50-10167

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10167

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

HOWARD L. SULLIVAN

2. DATE
OF
DEATH

11/25/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF
HOSPITAL OR
INSTITUTION

St. Agnes Hosp.

C. Length of stay in Baltimore

40 Yrs.

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

M

10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

PRINTER

10B. KIND OF BUSINESS OR
INDUSTRY

Printing

13. FATHER'S NAME

George T. Sullivan

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

214-01-7140

4. USUAL RESIDENCE (Where deceased lived. If institution: residence
before admission)

A. STATE

MD.

B. COUNTY

#23 BALTIMORE

C. CITY OR TOWN

BALTIMORE

D. STREET ADDRESS (If rural, give location)

295. Arlington Ave

8. DATE OF BIRTH

2/28/1878

9. AGE (in years
last birthday)

72

11 Under 1 Year
Months: Days11 Under 24 Hours
Hours: Min.

11. BIRTHPLACE (State or foreign country)

MD

12. CITIZEN OF
WHAT COUNTRY?

USA

14. MOTHER'S MAIDEN NAME

Lula I. Kinnamon

17. INFORMANT

Grace E. Sullivan

ADDRESS

295. Arlington Ave

18.

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

CAUSE OF DEATH

(A) GASTRIC CARCINOMA

DUE TO GENERALIZED

(B) CARCINOMATOSIS -

DUE TO Cachexia

(C) Cachexia

INTERVAL BETWEEN
ONSET AND DEATHOTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

MALNUTRITION

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDER-
LYING OR CONTRIBUTING
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT
WORK ☐ NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11/20, 1950, to 11/25, 1950 that I last saw the
deceased alive on 11/25, 1950, and that death occurred at 11:50 a.m., from the causes and on the date stated above.

23A. SIGNATURE

M. D.

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

NOV 28 1950

Huntington Williams, Md.

E. Miles Lamoreau Liberty Hgts Ave

VS 150

512 4M

046 L

MEDICAL CERTIFICATION

Richard

M/10/19/19

50-10168

50-10168

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED
(Type or Print)

Herman Pimes

2. DATE
OF
DEATH

November 27, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR INSTITUTION 3706 Nortonia Road

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
BaltimoreD. STREET ADDRESS (If rural, give location)
1727 Ruxton Ave

c. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)
Single

8. DATE OF BIRTH

1880

9. AGE (In years
last birthday)

70

If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)
Cutter Tailor10B. KIND OF BUSINESS OR
INDUSTRY
CLOTHING (M)

11. BIRTHPLACE (State or foreign country)

Baltimore Md

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Solomon Pimes

14. MOTHER'S MAIDEN NAME

Celia ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

215-01-6426

17. INFORMANT

ADDRESS

Sol Pimes 1101 Ridgely St

18.

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A)

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.INTERVAL BETWEEN
ONSET AND DEATH

1 Day

2 mos.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE
HOMICIDE (Specify) No21B. PLACE OF INJURY (e.g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov. 27, 1950, to Nov. 27, 1950, that I last saw the
deceased alive on Nov. 26, 1950, and that death occurred at 7 A. M., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)
Burial

24B. DATE

Nov 29, 1950

24C. NAME OF CEMETERY OR CREMATORY

Aitz Chaim Cong Cemetery

24D. LOCATION (City, town, or county)

Washington Blvd Balto Md

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

NOV 28 1950

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MEDICAL CERTIFICATION

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DEPARTMENT OF THE ARMY

OFFICE OF THE CHIEF OF STAFF

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626
REA-141429BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10169

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH	
Idella Halley Parker		Nov. 26, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION Baltimore City Hospitals 4940 Eastern Avenue		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore	
c. Length of stay in Baltimore Life		D. STREET ADDRESS (If rural, give location) 921 Whatcoat Street	
5. SEX Female	6. COLOR OR RACE Negro	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH June 8, 1910
9. AGE (In years last birthday) 40		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME John Parker		14. MOTHER'S MAIDEN NAME Mary King (D)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Records: B. C. H.		ADDRESS 4940 Eastern Avenue	

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) DUE TO Pulmonary Tuberculosis, far advanced (A)	INTERVAL BETWEEN ONSET AND DEATH Unknown
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (B)	
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. DUE TO (C)	

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9-7, 1950, to 11-26, 1950, that I last saw the deceased alive on 11-26, 1950, and that death occurred at 3:25 A.M., from the causes and on the date stated above.

23A. SIGNATURE H. C. C. C.	23B. ADDRESS M. D. 4940 Eastern Avenue	23C. DATE SIGNED 11-27-50
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24A. BURIAL, CREMATION, REMOVAL (Specify) Burial	24B. DATE 11/30/50	24C. NAME OF CEMETERY OR CREMATORY Arbutus Memorial Park	24D. LOCATION (City, town, or county) (State) Md
DATE RECEIVED BY LOCAL REGISTRAR NOV 28 1950	REGISTRAR'S SIGNATURE Wm. J. Williams, M.D.	25. FUNERAL DIRECTOR Geo. S. Nelson	ADDRESS 1303 Presiding

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STATE OF TEXAS

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634
50-10170
BIRTH NO.BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50-10170
Registered No.

1. NAME OF DECEASED (Type or Print) <i>Frederick J. Kroedel</i>		2. DATE OF DEATH <i>NOV. 26, 1950</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Ind.</i> B. COUNTY	
5. FULL NAME OF HOSPITAL OR INSTITUTION <i>2556 Wilkens Ave.</i>		C. CITY OR TOWN (If outside corporate limits, write FULL name and give township) <i>Baltimore</i> <i>20-05</i>	
6. Length of stay in Baltimore <i>Life</i>		D. STREET ADDRESS (If rural, give location) <i>2556 Wilkens Ave.</i>	
7. SEX <i>Male</i>	8. COLOR OR RACE <i>White</i>	9. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Married</i>	10. DATE OF BIRTH <i>July 9, 1891</i>
10A. USUAL OCCUPATION (Give kind of work or business, must state if retired) <i>Plumbers Helper</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Employed by Joseph Ruth PLUMBING CONT.</i>	
11. FATHER'S NAME <i>Herman Kroedel</i>		12. BIRTHPLACE (State or foreign country) <i>Balto. Md.</i>	
13. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		14. CITIZEN OF WHAT COUNTRY?	
15. SOCIAL SECURITY NO.		16. MOTHER'S MAIDEN NAME <i>Elizabeth----</i>	
17. INFORMANT <i>Mrs. Amelia M. Kroedel</i>		18. ADDRESS <i>2556 Wilkens Ave.</i>	

18. <i>420.1</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Coronary Disease</i>		19. INTERVAL BETWEEN ONSET AND DEATH
20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <i>(A) DUE TO</i> <i>(B) DUE TO</i> <i>(C)</i>		
21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		
22. DATE OF OPERATION <i>420.1</i>	23. MAJOR FINDINGS OF OPERATION	24. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
25. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	26. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	27. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
28. TIME (Month) (Day) (Year) (Hour) OF INJURY	29. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE <input type="checkbox"/> AT WORK	30. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an *Inspection* thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE <i>Wm. H. Kammer, Jr.</i>		23B. CHIEF MEDICAL EXAMINER..... ASSISTANT MEDICAL EXAMINER..... MEDICAL INVESTIGATOR.....		23C. DATE SIGNED <i>Nov. 27, 1950</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>Nov. 30, 1950</i>		24C. NAME OF CEMETERY OR CREMATORY <i>New Cathedral</i>	
24D. LOCATION (City, town or county, State) <i>4300 Old Frederick Rd. Balto. Md.</i>		24E. LOCATION (City, town or county, State)		24F. LOCATION (City, town or county, State)	

25. DATE RECEIVED BY LOCAL REGISTRAR <i>NOV 28 1950</i>	26. REGISTRAR'S SIGNATURE <i>William M. ...</i>	27. FUNERAL DIRECTOR <i>Harry H. ...</i>	28. ADDRESS <i>4101 Edmondson Ave.</i>
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**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

Registered No. **50-10171**

1. NAME OF DECEASED (Type or Print) MARY-CATHERINE Hagemann		2. DATE OF DEATH Nov-25-1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland Baltimore		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Balto. MD B. COUNTY 9-04	
B. FULL NAME OF HOSPITAL OR INSTITUTION 2609 Greenmount Ave		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto - MD	
c. Length of stay in Baltimore 47 years		D. STREET ADDRESS (If rural, give location) 2609 Greenmount Ave	
5. SEX F	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH June 24-1903
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years, last birthday) 47
13. FATHER'S NAME Samuel H. Ziegler		11. BIRTHPLACE (State or foreign country) Baltimore-MD	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or not known) No		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
16. SOCIAL SECURITY NO.		14. MOTHER'S MAIDEN NAME Rose Larrabee	
17. INFORMANT		ADDRESS	

18. 162X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Antecedent Causes DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	CAUSE OF DEATH (A) Bronchiogenic Carcinoma with Lumbar Vertebral Metastasis DUE TO (B) DUE TO (C)	INTERVAL BETWEEN ONSET AND DEATH 7 mos.
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19A. DATE OF OPERATION 0		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from **Sept. 1949**, to **Nov. 25, 1950**, that I last saw the deceased alive on **Nov. 23, 1950**, and that death occurred at **6 P.** m., from the causes and on the date stated above.

23A. SIGNATURE Wm. H. Kammner, J. M. D.	23B. ADDRESS 501 Sheridan Ave.	23C. DATE SIGNED Nov. 27, 1950
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24A. BURIAL, CREMATION, REMOVAL (Specify) Burial	24B. DATE Nov-29-50	24C. NAME OF CEMETERY OR CREMATORY POCKWOOD	24D. LOCATION (City, town, or county) (State) BALTO - MD
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DATE RECEIVED BY LOCAL REGISTRAR NOV 28 1950	REGISTRAR'S SIGNATURE William Williams, M.D.	25. FUNERAL DIRECTOR Bay B. Whitman	ADDRESS 403-E-25th St 047c
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OFFICE OF THE ATTORNEY GENERAL

100-100



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BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10172

Registered No.

0-10172

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

FREDERICK S. KARL

2. DATE
OF
DEATH

26 Nov 50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or hospital or institution)

Good Samaritan Hosp.
27 W. Carey St

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write full name, and give township)

Md
Baltimore

D. STREET ADDRESS (If rural, give location)

423 W. Sabaloga St.

c. Length of stay in Baltimore

about 50 yrs

5. SEX

male

6. COLOR OR RACE

white

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

June 21, 1880

9. AGE (In years last birthday)

70

10 Under 1 Year

Months: Days Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Watchman

10B. KIND OF BUSINESS OR INDUSTRY

Bank

11. BIRTHPLACE (State or foreign country)

Cleveland, Ind.

12. CITIZEN OF

WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME

George F. Karl

14. MOTHER'S MAIDEN NAME

Opolnia Eichorn

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown)

16. SOCIAL SECURITY NO.

213-03-5890

17. INFORMANT

ADDRESS

Miss Bertha Karl 3019 Wylie Ave

18. 420.1

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e.g., in or
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 14 Nov, 1950, to 26 Nov, 1950, that I last saw the deceased alive on 25 Nov, 1950, and that death occurred at 9 PM m., from the causes and on the date stated above.

23A. SIGNATURE

Emil H. Henning Jr

M. D.

23B. ADDRESS

601 W. Winans Way

23C. DATE SIGNED

27 Nov 50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY
LOCAL REGISTRAR

NOV 28 1950

REGISTRAR'S SIGNATURE

Emil H. Henning Jr

25. FUNERAL DIRECTOR

Long Evers

ADDRESS

5005 R. Light St

VS 150

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MEDICAL CERTIFICATION

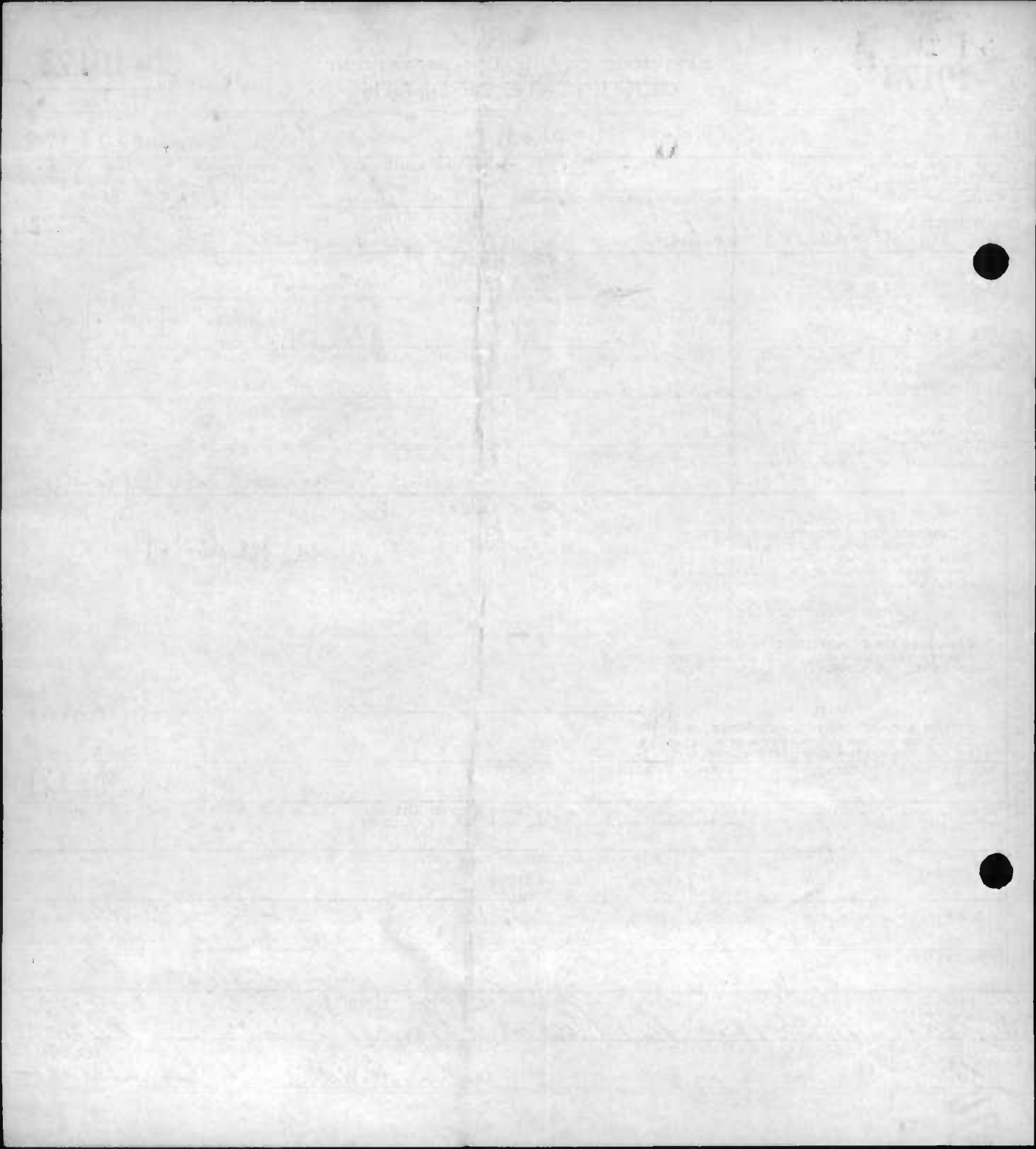
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50-10173

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10173
Registered No.

1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH	
Sandy Stephens.		November 24, 1950.	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION 423 Mott St.		C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township) Baltimore.	
c. Length of stay in Baltimore Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) 423 Mott St.	
5. SEX Male	6. COLOR OR RACE C	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Divorced	8. DATE OF BIRTH 1905
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) mechanic		10B. KIND OF BUSINESS OR INDUSTRY Construction Work	9. AGE (In years last birthday) 45
11. BIRTHPLACE (State or foreign country) Waterboro, S.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry Stephens.		14. MOTHER'S MAIDEN NAME Essie	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Etheline Braxton.		ADDRESS 2504 Druid Hill Ave.	
18. 490X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH Pneumonia		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 11/24, 1950, to 11/24, 1950, that I last saw the deceased alive on 11/24, 1950 and that death occurred at 7 P. M., from the causes and on the date stated above.			
23A. SIGNATURE B. A. Rutter, Sr.		23B. ADDRESS 2134 W. 1st St.	
23C. DATE SIGNED			
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-28-1950	
24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem.		24D. LOCATION (City, town or county) (State) Balto. Md.	
DATE RECEIVED BY LOCAL REGISTRAR NOV 28 1950		25. FUNERAL DIRECTOR Mrs. Katie R. Williams	
REGISTRAR'S SIGNATURE Theresa J. Williams		ADDRESS 322 N. Schroeder St.	

MEDICAL CERTIFICATION



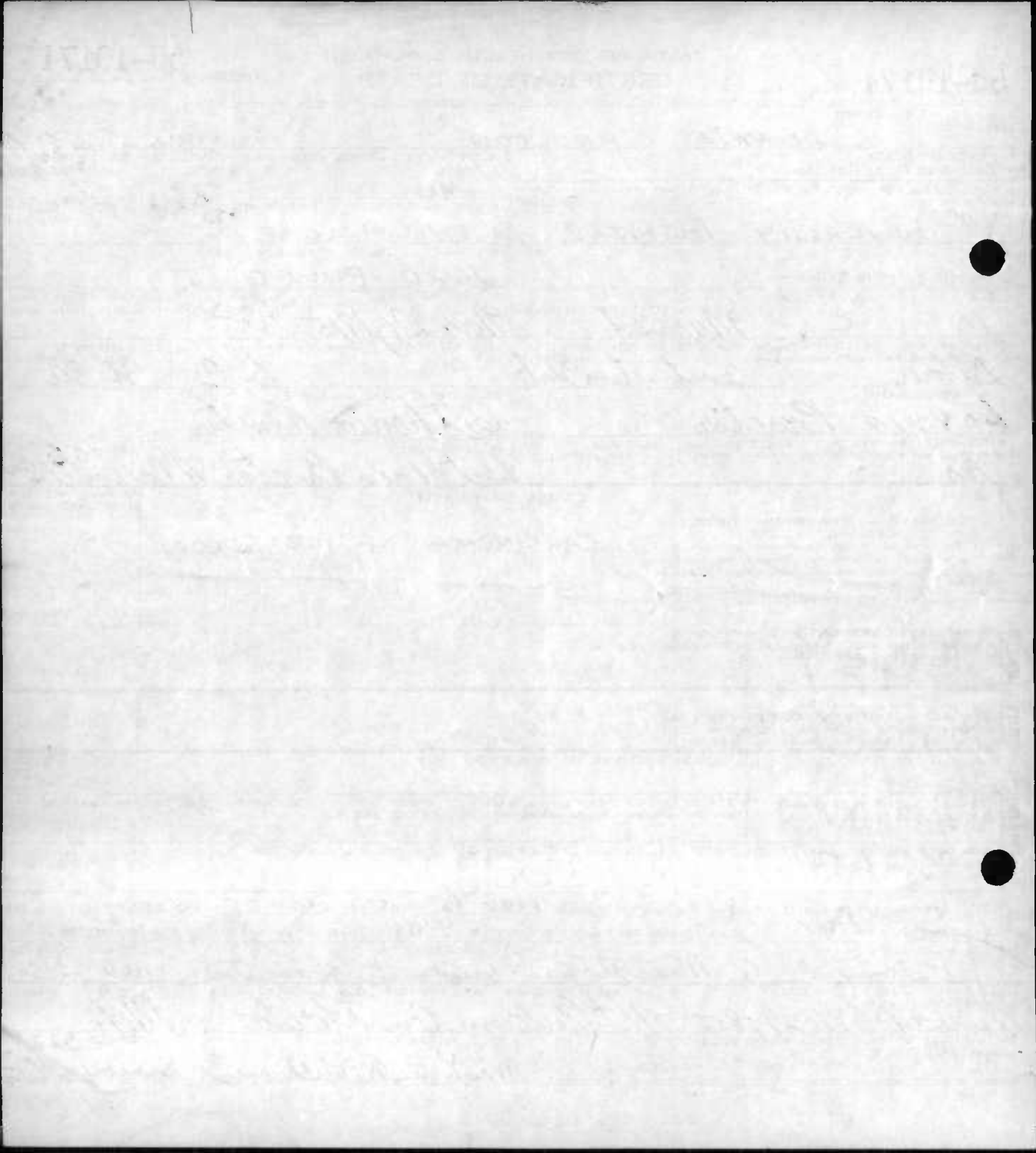
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50-10174

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50-10174

1. NAME OF DECEASED (Type or Print) LONNIE PROCTOR		2. DATE OF DEATH NOV. 25, 50	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY BALTIMORE	
B. FULL NAME OF HOSPITAL OR INSTITUTION UNIVERSITY HOSPITAL		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE	
c. Length of stay in Baltimore Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) 2620 PUGET ST.	
5. SEX M	6. COLOR OR RACE C	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Nov. 24, 1915
10A. USUAL OCCUPATION (Give kind of work done during most of worklog life, even if retired) Labour		10B. KIND OF BUSINESS OR INDUSTRY Construction Work	9. AGE (In years last birthday) 35
13. FATHER'S NAME Lonnie Proctor		14. MOTHER'S MAIDEN NAME Bethenia Kimster	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Bethenia Proctor N. Carroll	
18. 153X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CARCINOMA OF THE COLON		INTERVAL BETWEEN ONSET AND DEATH -	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO (C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION 0		19B. MAJOR FINDINGS OF OPERATION	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from NOV 15, 1950 , to NOV 25, 1950 that I last saw the deceased alive on NOV 25, 1950 , and that death occurred at 4:45 P.M. , from the causes and on the date stated above.			
23A. SIGNATURE Edmund B. Middleton		23B. ADDRESS University Hospital	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-29-1950	
24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem Balto.		24D. LOCATION (City, town, or county) (State) Md.	
DATE RECEIVED BY LOCAL REGISTRAR NOV 28 1950		25. FUNERAL DIRECTOR Mrs. Katie R. Williams	
REGISTRAR'S SIGNATURE William H. Williams		ADDRESS 322 N. Schroeder St.	

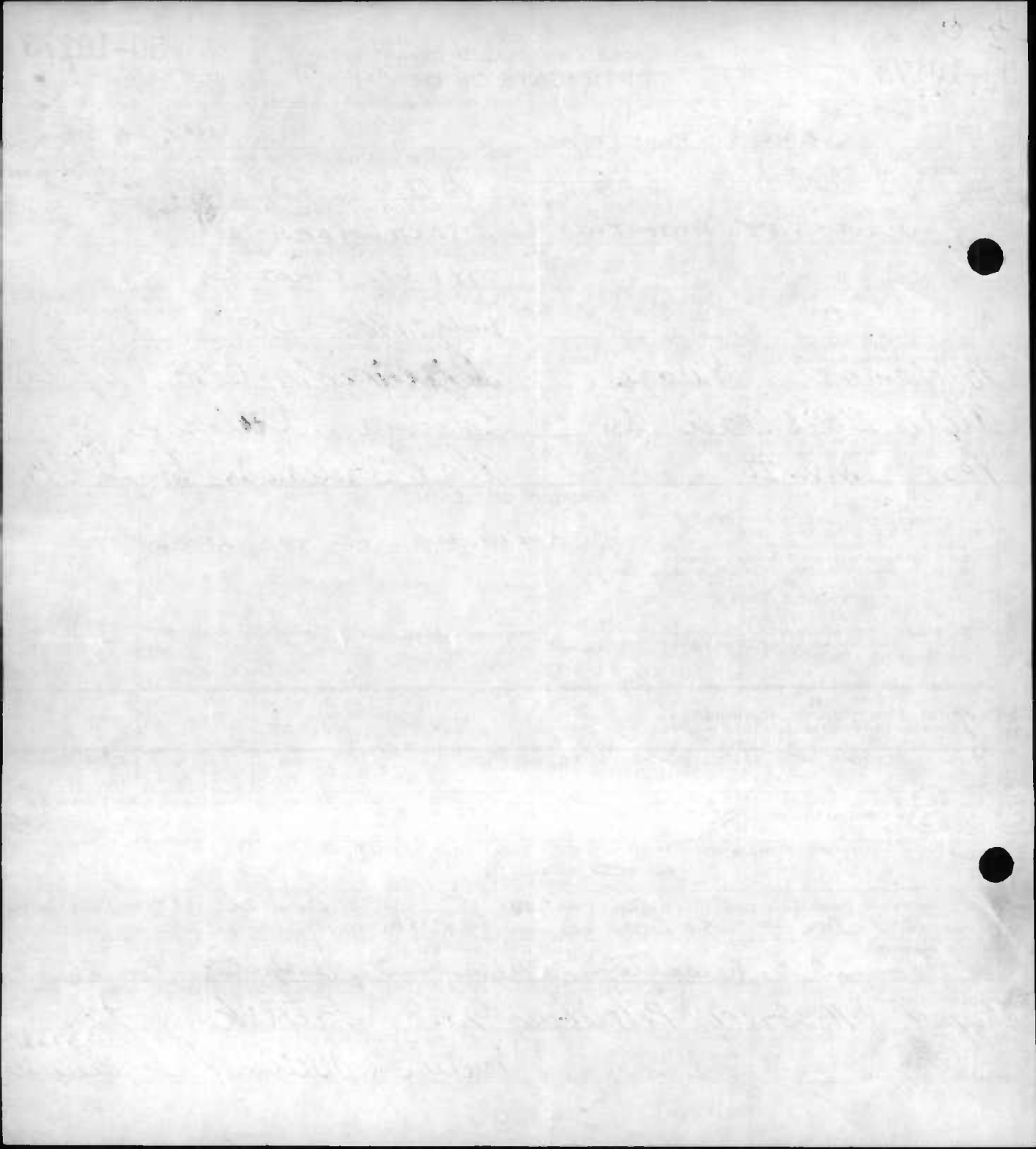


200
50-10175
BIRTH NO.BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10175

Registered No.

1. NAME OF DECEASED (Type or Print) JAMES BOISSEAU			2. DATE OF DEATH NOV, 26, '50		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE MD. B. COUNTY HARFORD		
5. FULL NAME OF HOSPITAL OR INSTITUTION UNIVERSITY HOSPITAL			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE		
c. Length of stay in Baltimore Yrs. Mos. Days			D. STREET ADDRESS (If rural, give location) 781 W. SARATOGA		
5. SEX M	6. COLOR OR RACE C	7. SINGLE, MARRIED, WIDOWED DIVORCED (Specify)	8. DATE OF BIRTH July 4, 1905	9. AGE (In years last birthday) 45	If Under 1 Year Months: Days If Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work during most of working life, even if retired) Mechanic		10B. KIND OF BUSINESS OR INDUSTRY Garage		11. BIRTHPLACE (State or foreign country) Petersburg Co. Va	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Algie Boisseau Sr.		14. MOTHER'S MAIDEN NAME Lurina Ottinson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. W.W. II		17. INFORMANT Algie Boisseau Jr	
18. 156.1		CAUSE OF DEATH CARCINOMA OF THE LIVER		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO			
ANTECEDENT CAUSES		(B) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Nov 15, 1950 , to Nov 26, 1950 , that I last saw the deceased alive on Nov 26, 1950 , and that death occurred at 8:45 A.M. , from the causes and on the date stated above.					
23A. SIGNATURE Edmund B. Middleton		23B. ADDRESS University Hospital		23C. DATE SIGNED Nov 26, 50	
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE 11-28-1950		24C. NAME OF CEMETERY OR CREMATORY Petersburg Va.	
24D. LOCATION (City, town, or county) Petersburg Va.		24E. STATE Va.		24F. ADDRESS 322 N. Schuman St.	
DATE RECEIVED BY LOCAL REGISTRAR NOV 28 1950		REGISTRAR'S SIGNATURE Thurston Williams		25. FUNERAL DIRECTOR Mrs. Katie R. Williams	



000
50-10176

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10176
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) LEE, FRANK JAMES			2. DATE OF DEATH 11/26/50		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE md. B. COUNTY		
B. FULL NAME OF HOSPITAL OR INSTITUTION Provident			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore		
c. Length of stay in Baltimore			D. STREET ADDRESS (If rural, give location) 1307 W. Mulberry		
5. SEX Male	6. COLOR OR RACE Negro	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 8/7/1905	9. AGE (In years last birthday) 45	10. Under 1 Year Months: Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Porter			11. BIRTHPLACE (State or foreign country) Richmond Va.		
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME James Lee		
14. MOTHER'S MAIDEN NAME ?			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No.		
16. SOCIAL SECURITY NO.			17. INFORMANT Iris Lee		
18. ADDRESS			19. ADDRESS		

18. 443X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Hypertensive Heart Disease DUE TO Uremia Anemia Anemia	CAUSE OF DEATH Hypertensive Heart Disease Uremia Anemia Anemia	INTERVAL BETWEEN ONSET AND DEATH
--	--	----------------------------------

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

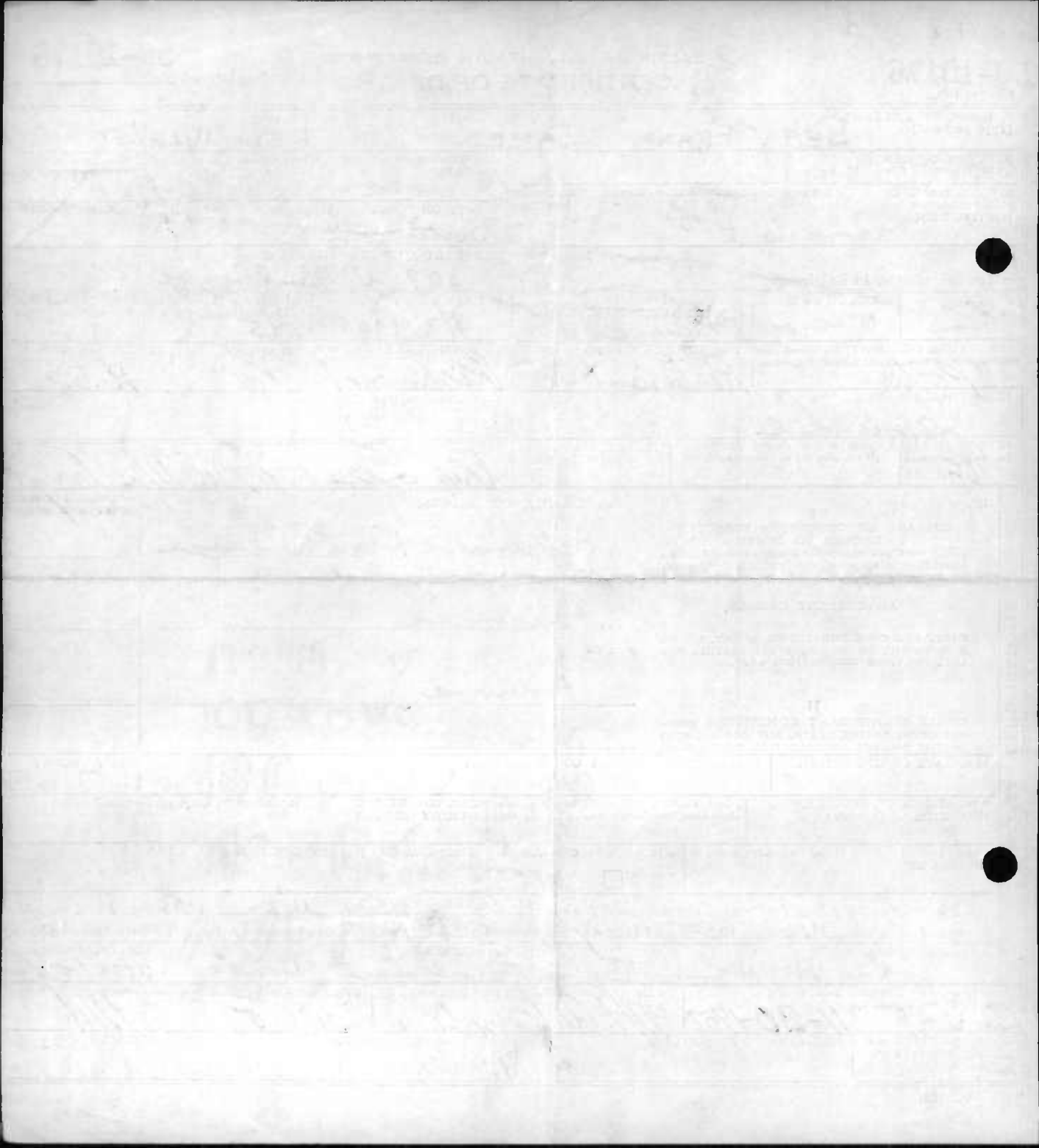
22. I hereby certify that I attended the deceased from **11/24** 19**50**, to **11/26**, 19**50**, that I last saw the deceased alive on **11/25**, 19**50**, and that death occurred at **12:40** A. M., from the causes and on the date stated above.

23A. SIGNATURE John N. Holmes III	23B. ADDRESS Provident Hosp.	23C. DATE SIGNED 11/26/50
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial	24B. DATE 11-30-1950	24C. NAME OF CEMETERY OR CREMATORY W. C. C. Cemetery
24D. LOCATION (City, town, or county) (State) Balto. Md.	25. FUNERAL DIRECTOR Mrs. Katie R. Williams	ADDRESS 322 N. Schroeder St.

DATE RECEIVED BY LOCAL REGISTRAR
NOV 28 1950

780 6M

093d



**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

Registered No. **50-10177**

50-10177

1. NAME OF DECEASED (Type or Print) <i>Edward Marchand</i>			2. DATE OF DEATH <i>Nov. 28, 1950</i>		
3. PLACE OF DEATH: A. Baltimore City, Maryland <i>1200 Valley St.</i>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i>		
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>Little Sisters of the Poor</i>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore</i>		
C. Length of stay in Baltimore			D. STREET ADDRESS (If rural, give location) <i>1200 Valley St.</i>		
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Single</i>	8. DATE OF BIRTH <i>June 18, 1872</i>		9. AGE (in years last birthday) <i>78</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>New York</i>	
13. FATHER'S NAME <i>Hubert Marchand</i>			14. MOTHER'S MAIDEN NAME <i>Mary Ann Cheney</i>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <i>Little Sisters of the Poor</i>	

18. <i>4221 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	CAUSE OF DEATH (A) <i>Acute Dilatation of Heart</i> DUE TO (B) <i>Chronic Myocarditis</i> DUE TO (C) <i>Arterio Sclerosis</i>	INTERVAL BETWEEN ONSET AND DEATH <i>1 day -</i> <i>5 yrs</i> <i>10 yrs</i>
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19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	

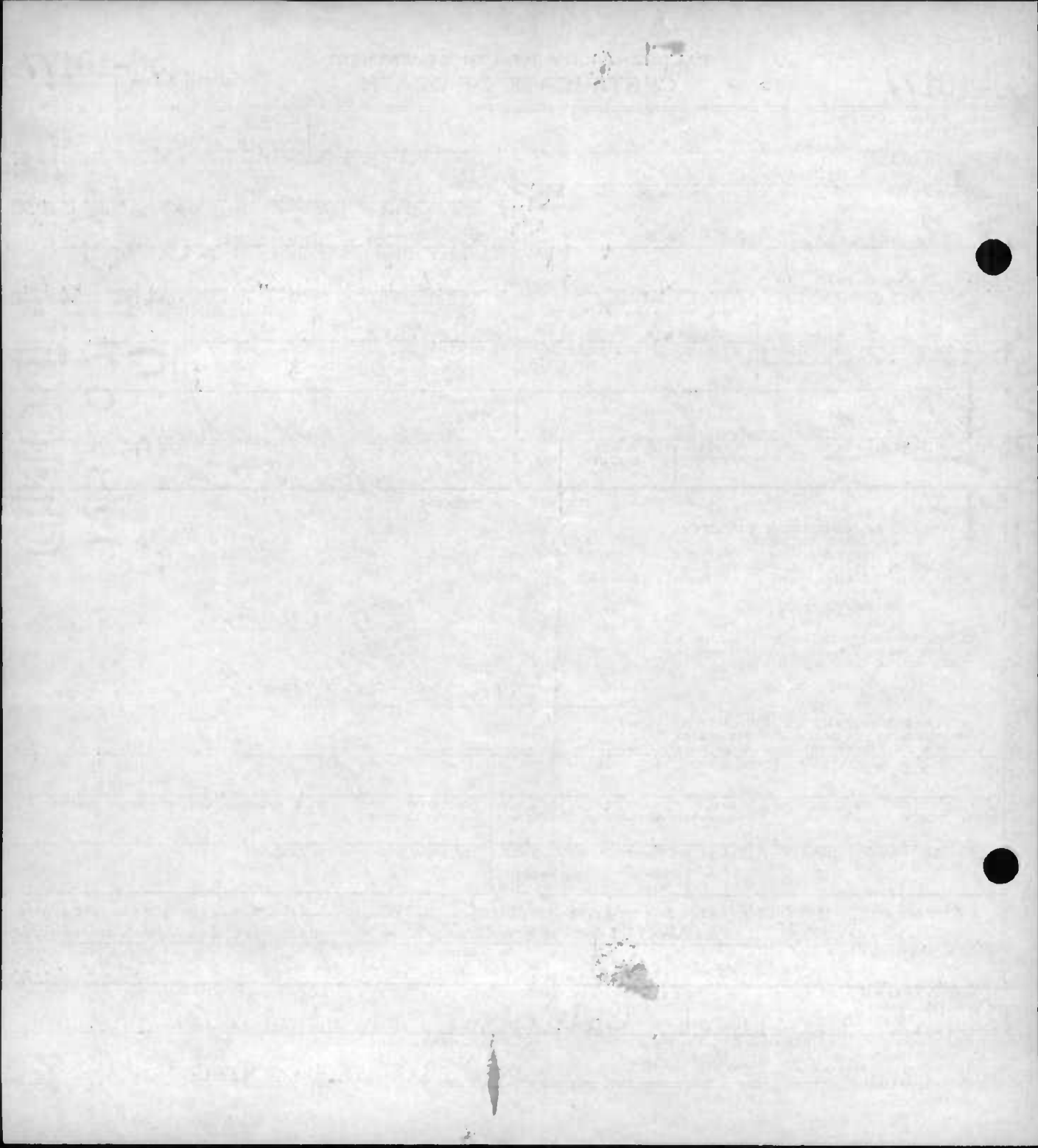
22. I hereby certify that I attended the deceased from *Sept 1 -*, 19*50*, to *Nov 28*, 19*50*, that I last saw the deceased alive on *Nov 27 -*, 19*50*, and that death occurred at *10 A* m., from the causes and on the date stated above.

23A. SIGNATURE <i>E. G. Hall M.D.</i>		23B. ADDRESS <i>1631 E North Ave</i>		23C. DATE SIGNED <i>Nov 28-1950</i>	
--	--	---	--	--	--

24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>Nov. 29, 1950</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Cathedral</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore</i>	
--	--	-----------------------------------	--	--	--	---	--

DATE RECEIVED BY LOCAL REGISTRAR <i>NOV 28 1950</i>		REGISTRAR'S SIGNATURE <i>William Williams, M.D.</i>		25. FUNERAL DIRECTOR ADDRESS <i>Edna Wiedefeld 900 E. Biddle St</i>	
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MEDICAL CERTIFICATION



S-436
50-10178BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10178

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

3. PLACE OF DEATH:

A. Baltimore City, Maryland 3937 Cantlinbury

B. FULL NAME OF (If not in hospital or institution, give street address or location)
at home

c. Length of stay in Baltimore Life

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Married

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Retired Lawyer & Judge

10B. KIND OF BUSINESS OR INDUSTRY

Lawyer & Judge

13. FATHER'S NAME

John Soller

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

None

2. DATE OF DEATH

Nov-27-50

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)

A. STATE B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

3937 Cantlinbury Rd

8. DATE OF BIRTH

May-14-1873

9. AGE (In years last birthday)

77 yrs

11 Under 1 Year Months Days

11 Under 24 Hours Hours Min.

11. BIRTHPLACE (State or foreign country)

Baltimore Md.

12. CITIZEN OF WHAT COUNTRY?

USA

14. MOTHER'S MAIDEN NAME

Mary C. Taylor

17. INFORMANT

Mrs. Christie Soller (sister)

ADDRESS

Baltimore

18. 420.0

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis

DUE TO

INTERVAL BETWEEN ONSET AND DEATH

4 da.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Arteriosclerotic heart disease

DUE TO

10 yr.

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept 29, 1949, to Nov 27, 1950, that I last saw the deceased alive on Nov 27, 1950 and that death occurred at 1 P.m., from the causes and on the date stated above.

23A. SIGNATURE

H. R. Freeman Jr.

M. O.

23B. ADDRESS

11 W. 29th St.

23C. DATE SIGNED

Nov 27, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

Nov 29/50

24C. NAME OF CEMETERY OR CREMATORY

Dorsey Ridge

24D. LOCATION (City, town, or county)

Baltimore Md.

(State)

DATE RECEIVED BY LOCAL REGISTRAR

NOV 29 1950

REGISTRAR'S SIGNATURE

[Signature]

25. FUNERAL DIRECTOR

Brewster-Morris Co.

ADDRESS

Baltimore

STATE OF NEW YORK

IN SENATE

JANUARY 10, 1917

REPORT

OF THE

COMMISSIONERS OF THE LAND OFFICE

IN RESPONSE TO A RESOLUTION PASSED BY THE SENATE, MAY 1, 1916, CONCERNING THE LANDS BELONGING TO THE STATE.

ALBANY:

JOHN W. BAKER, PRINTING OFFICE.

1917.

NEW YORK:

THE STATE OF NEW YORK.

THE COMMISSIONERS OF THE LAND OFFICE.

ALBANY.

THE STATE OF NEW YORK.

THE COMMISSIONERS OF THE LAND OFFICE.

ALBANY.

THE STATE OF NEW YORK.

THE COMMISSIONERS OF THE LAND OFFICE.

ALBANY.

THE STATE OF NEW YORK.

THE COMMISSIONERS OF THE LAND OFFICE.

ALBANY.

500
50-10179BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50-10179

1. NAME OF DECEASED (Type or Print) Mary Ellen Ryan,			2. DATE OF DEATH Nov. 25, 1950		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY		
B. FULL NAME OF HOSPITAL OR INSTITUTION 4916 Cordelia Ave.,			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore,		
C. Length of stay in Baltimore life			D. STREET ADDRESS (If rural, give location) 4916 Cordelia Ave.,		
5. SEX female	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widow	8. DATE OF BIRTH March 4, 1872	9. AGE (in years last birthday) 78	10. Under 1 Year Months: Days 11. Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10B. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME James Considine,		
14. MOTHER'S MAIDEN NAME Susan McDonnell.			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		
16. SOCIAL SECURITY NO. none			17. INFORMANT ADDRESS Mrs. Sue Kreinert, 4916 Cordelia Ave.,		
18. 420.0 CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Heart Disease DUE TO INTERVAL BETWEEN ONSET AND DEATH 2 years					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO (C) DUE TO					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Fracture of Head of Femur INTERVAL BETWEEN ONSET AND DEATH 2 years ago					
19A. DATE OF OPERATION 0			19B. MAJOR FINDINGS OF OPERATION		
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY			21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
21F. HOW DID INJURY OCCUR?			22. I hereby certify that I attended the deceased from OCT 1 , 19 48 , to Nov. 25 , 19 50 , that I last saw the deceased alive on Nov. 25 , 19 50 , and that death occurred at 11 P.m. , from the causes and on the date stated above.		
23A. SIGNATURE Marcel Levin			23B. ADDRESS 4818 Reisterstown Road.		
23C. DATE SIGNED 11/ /50			24A. BURIAL, CREMATION, REMOVAL (Specify) burial		
24B. DATE Nov. 29, 1950			24C. NAME OF CEMETERY OR CREMATORY St. Stephen's Cemetery,		
24D. LOCATION (City, town, or county) (State) Bradshaw, Md.			25. FUNERAL DIRECTOR ADDRESS 4611 Park Heights Ave.		
DATE RECEIVED BY LOCAL REGISTRAR NOV 29 1950			REGISTRAR'S SIGNATURE Vernon L. L...		

"Fracture 2 years previous to death in no way contributed to her de

See Document File 50-10179

12/13/50 ES

230

50-10180

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10180

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

MARGARET ANNE WIGHT

2. DATE
OF
DEATH

Nov 28 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)

A. STATE

B. COUNTY

Ind.

5. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR INSTITUTION

1301 Park Ave

C. CITY OR TOWN

Baltimore

(If outside corporate limits, write RURAL and give township)

11-01

D. STREET ADDRESS (If rural, give location)

1301 St Paul St

Earl Combs Hts

c. Length of stay in Baltimore

Life

Yrs.
Mos.
Days

5. SEX

F

6. COLOR OR RACE

Wh

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

Mar 29 1872

9. AGE (In years,
last birthday)

78

10. Under 1 Year
Months: Days11. Under 24 Hours
Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

None

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore Md

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

John Hyatt Wight

14. MOTHER'S MAIDEN NAME

Mary Davison

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

E. Hyatt Wight.

ADDRESS

Same

18. 174X

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)

(A)

Cancer of uterus.

DUE TO

Cervical ectropion

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

Artificial Abortion

(C)

INTERVAL BETWEEN
ONSET AND DEATH1 year
1 month

1 year

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e.g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 1st 1950, to Nov 28th 1950, that I last saw the deceased alive on Nov 27th 1950, and that death occurred at 11:30 a.m., from the causes and on the date stated above.

23A. SIGNATURE

J. H. Chatard

M. D.

23B. ADDRESS

15 E. Biddle St

23C. DATE SIGNED

Nov 29/50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

Nov 30 1950

24C. NAME OF CEMETERY OR CREMATORY

Druid Ridge

24D. LOCATION (City, town, or county)

Pikesville Md

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Henry M. Jenkins

25. FUNERAL DIRECTOR

Henry M. Jenkins & Sons Co 4905 York Rd

ADDRESS

NOV 29 1950

Dr. J. Albert Chalmers
15 E. Biddle St

523

50-10181

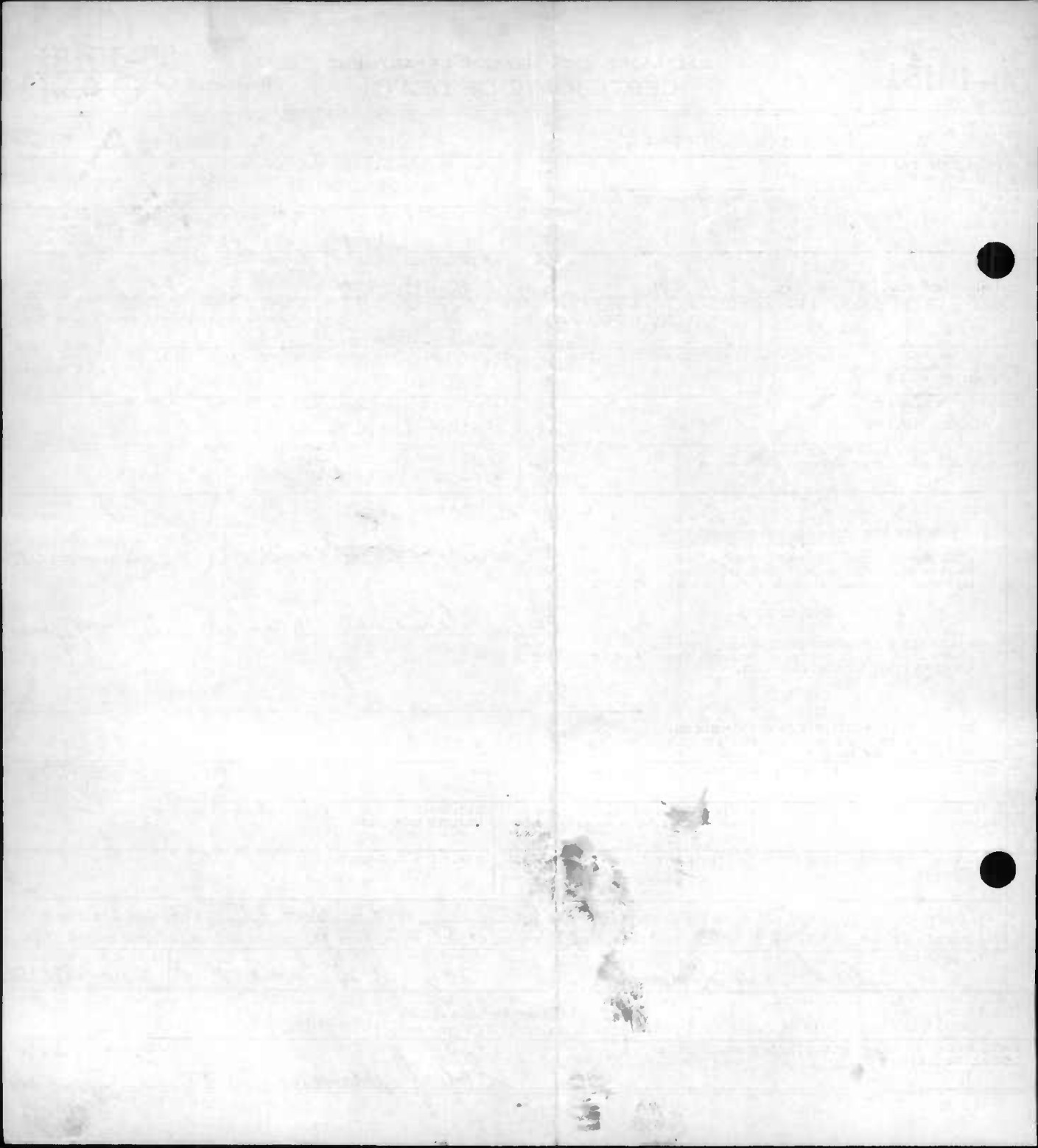
BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10181

Registered No.

1. NAME OF DECEASED (Type or Print) Sarah Einstendig		2. DATE OF DEATH November 28, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION 5535 Gist Ave		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore	
C. Length of stay in Baltimore 30 Yrs Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) 5535 Gist Ave	
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Sept 14, 1899
9. AGE (In years last birthday) 51		10. Under 1 Year Months: Days Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Poland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Sol Better		14. MOTHER'S MAIDEN NAME Esther Shapiro	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mr Sam Einstendig		ADDRESS 5535 Gist Ave	
18. 447 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) Cerebral Accident (Embolic) Immediate DUE TO (B) Hypertensive Vascular Disease Many years DUE TO (C) INTERVAL BETWEEN ONSET AND DEATH II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Jan 1948, to Nov 28, 1950, that I last saw the deceased alive on Nov. 27, 1950, and that death occurred at 5:30 p.m., from the causes and on the date stated above.			
23A. SIGNATURE Abram Goldman M.D.		23B. ADDRESS 206 S. Elmor St.	
23C. DATE SIGNED Nov. 28, 1950			
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE Nov 29, 1950	
24C. NAME OF CEMETERY OR CREMATORY Hebrew Rosedale Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore Md	
DATE RECEIVED BY LOCAL REGISTRAR NOV 29 1950		REGISTRAR'S SIGNATURE Sol Lewinson Bms	
25. FUNERAL DIRECTOR Sol Lewinson Bms		ADDRESS 1126 W North ave	

MEDICAL CERTIFICATION



200
50-10182-143560
BIRTH NO.BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10182

Registered No.

1. NAME OF DECEASED (Type or Print) Kenneth Allan Boyce (Alan)		2. DATE OF DEATH Nov. 27, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION Baltimore City Hospitals 4940 Eastern Avenue		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore	
c. Length of stay in Baltimore Life		D. STREET ADDRESS (If rural, give location) Henryton Hosp. 629 Fulton Ave. N.	
5. SEX Male	6. COLOR OR RACE Negro	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH Sept. 28, 1949
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		9. AGE (In years last birthday) 13	11. BIRTHPLACE (State or foreign country) Maryland
10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME George Boyce		14. MOTHER'S MAIDEN NAME Margaret Corcey (Corsey)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.	
17. INFORMANT Records: B. C. H. 4940 Eastern Avenue		ADDRESS	

18. O I O X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Tuberculous Meningitis DUE TO (A) Tuberculous Meningitis DUE TO (B) DUE TO (C) INTERVAL BETWEEN ONSET AND DEATH 9 or 10 months	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	

19A. DATE OF OPERATION 11-29-50		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from **11-21**, 1950, to **11-27**, 1950, that I last saw the deceased alive on **11-27**, 1950, and that death occurred at **1:30 A.** from the causes and on the date stated above.

23A. SIGNATURE W. Crozen	23B. ADDRESS 4940 Eastern Avenue	23C. DATE SIGNED 11-27-50
------------------------------------	--	-------------------------------------

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial	24B. DATE 11-29-50	24C. NAME OF CEMETERY OR CREMATORY mt calvary am.	24D. LOCATION (City, town, or county) (State) Brooklyn md
DATE RECEIVED BY LOCAL REGISTRAR NOV 29 1950	REGISTRAR'S SIGNATURE W. Crozen	25. FUNERAL DIRECTOR Chas. O. Wilson 1100 Beauty	

100-100000

REPUBLIC OF DEATH

100-100000



246
50-10183BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50-10183
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

CHARLES RAYMOND McELROY

2. DATE
OF
DEATH

11-27-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or
HOSPITAL OR location)
INSTITUTION UNION MEMORIAL HOSPITAL4. USUAL RESIDENCE (Where deceased lived. If institution: residence
A. STATE B. COUNTY before admission)

Md.

Balto

C. CITY OR TOWN (If outside corporate limits, write full name and give township)

Balto 29

28-04

D. STREET ADDRESS (If rural, give location)

4410 Rokeby Ave Road.

c. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

M

8. DATE OF BIRTH

Oct. 23 1912

9. AGE (In years
last birthday)

38

If Under 1 Year
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Salesman

10B. KIND OF BUSINESS OR
INDUSTRY

Naval Stores (R)

11. BIRTHPLACE (State or foreign country)

Balto Md.

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Charles E McElroy

GEN. MOSE

14. MOTHER'S MAIDEN NAME

Clara M. Cook

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

Unknown

no

16. SOCIAL
SECURITY NO.

316-07-7747

17. INFORMANT

Mrs. Grace McElroy

ADDRESS Balto 29

4410 Rokeby Ave

18. E882.0

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A)

DUE TO

acute atrophy of liver

1 month

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

Carbon tetrachloride poisoning

1 month

(C)

CERTIFICATION APPROVED BY

Dr. Stanley H. Durlacher.

II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

per: William D. D.

DR. ASST. MEDICAL EXAMINER

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDER-
LYING OR CONTRIBUTING
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)

home

21C. WHERE DID (If in Baltimore City, give exact location)

INJURY OCCUR?

4410 Rokeby Road

21D. TIME (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT

NOT WHILE

WORK ☐AT WORK ☒

21F. HOW DID INJURY OCCUR?

Gallon jar of CCL₄ stored in kitchen
cracked and ran over floor. Overcome when22. I hereby certify that I attended the deceased from Nov. 2, 1950, to Nov. 27, 1950, that I last saw the
deceased alive on Nov. 27, 1950, and that death occurred at 11:10 P.M., from the causes and on the date stated above.

23A. SIGNATURE

Alfred S. Nelson

M. O.

23B. ADDRESS Union Memorial Hospital

23C. DATE SIGNED Nov 27/1950

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

Nov 30, 1950

24C. NAME OF CEMETERY OR CREMATORY

Woodlawn

24D. LOCATION (City, town, or county)

Baltimore Md

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

NOV 29 1950

William D. D.

25. FUNERAL DIRECTOR

ADDRESS

The Mrs. John G. G. 5311 Edmondson

VS 150

N-963.9

4906C

179x Ave.

MEDICAL CERTIFICATION

320
50-10184Kotowski
BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10184

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <i>Kenneth Kotowski</i>			2. DATE OF DEATH <i>11-27-50</i>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY		
5. FULL NAME OF HOSPITAL OR INSTITUTION <i>Sinai Hospital</i>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore</i> <i>2-02</i>		
6. Length of stay in Baltimore Yrs. Mos. Days			D. STREET ADDRESS (If rural, give location) <i>414 S. Regester Street</i>		
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>single</i>	8. DATE OF BIRTH <i>March 29, 1950</i>		9. AGE (In years last birthday) <i>78</i> Months: <i>29</i> Days: <i>29</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>Baltimore, Maryland</i>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <i>Leo Kotowski</i>			14. MOTHER'S MAIDEN NAME <i>Hedwig Czyz</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS <i>Leo Kotowski-414 S. Regester St.</i>		

18. <i>754.4</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	CAUSE OF DEATH (A) <i>Congenital Heart Disease</i> DUE TO (B) <i>Interatrial Septal Defect</i> DUE TO (C) <i>Congenital stenosis of mitral valve</i> <i>Pneumonia</i>	INTERVAL BETWEEN ONSET AND DEATH
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19A. DATE OF OPERATION <i>2</i>	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *11-27, 1950* to *11-27, 1950*, that I last saw the deceased alive on *11-27, 1950*, and that death occurred at *9:30 p.m.*, from the causes and on the date stated above.

23A. SIGNATURE <i>Indith B. Sandau</i> M. D.	23B. ADDRESS <i>Sinai Hospital Baltimore</i>	23C. DATE SIGNED <i>11-28-50</i>
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24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>Nov 30/50</i>	24C. NAME OF CEMETERY OR CREMATORY <i>Holy Rosary</i>	24D. LOCATION (City, town, or county) (State) <i>Baltimore</i>
DATE RECEIVED BY LOCAL REGISTRAR <i>NOV 29 1950</i>	REGISTRAR'S SIGNATURE <i>Frederick H. Grajewski</i>	25. FUNERAL DIRECTOR <i>Fred H. Grajewski</i>	ADDRESS <i>1930 Eastern Ave</i>

10-10181

STATE OF NEW YORK

10-10181

CERTIFICATE OF DEATH

10-10181

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>		<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>		<p>5. PLACE OF BIRTH</p>	
<p>6. OCCUPATION</p>		<p>7. CAUSE OF DEATH</p>		<p>8. MANNER OF DEATH</p>		<p>9. DATE OF DEATH</p>		<p>10. PLACE OF DEATH</p>	
<p>11. SIGNATURE OF DECEASED</p>		<p>12. SIGNATURE OF WITNESS</p>		<p>13. SIGNATURE OF PHYSICIAN</p>		<p>14. SIGNATURE OF CLERK</p>		<p>15. SIGNATURE OF JUDGE</p>	
<p>16. SIGNATURE OF DECEASED</p>		<p>17. SIGNATURE OF WITNESS</p>		<p>18. SIGNATURE OF PHYSICIAN</p>		<p>19. SIGNATURE OF CLERK</p>		<p>20. SIGNATURE OF JUDGE</p>	
<p>21. SIGNATURE OF DECEASED</p>		<p>22. SIGNATURE OF WITNESS</p>		<p>23. SIGNATURE OF PHYSICIAN</p>		<p>24. SIGNATURE OF CLERK</p>		<p>25. SIGNATURE OF JUDGE</p>	
<p>26. SIGNATURE OF DECEASED</p>		<p>27. SIGNATURE OF WITNESS</p>		<p>28. SIGNATURE OF PHYSICIAN</p>		<p>29. SIGNATURE OF CLERK</p>		<p>30. SIGNATURE OF JUDGE</p>	
<p>31. SIGNATURE OF DECEASED</p>		<p>32. SIGNATURE OF WITNESS</p>		<p>33. SIGNATURE OF PHYSICIAN</p>		<p>34. SIGNATURE OF CLERK</p>		<p>35. SIGNATURE OF JUDGE</p>	
<p>36. SIGNATURE OF DECEASED</p>		<p>37. SIGNATURE OF WITNESS</p>		<p>38. SIGNATURE OF PHYSICIAN</p>		<p>39. SIGNATURE OF CLERK</p>		<p>40. SIGNATURE OF JUDGE</p>	
<p>41. SIGNATURE OF DECEASED</p>		<p>42. SIGNATURE OF WITNESS</p>		<p>43. SIGNATURE OF PHYSICIAN</p>		<p>44. SIGNATURE OF CLERK</p>		<p>45. SIGNATURE OF JUDGE</p>	
<p>46. SIGNATURE OF DECEASED</p>		<p>47. SIGNATURE OF WITNESS</p>		<p>48. SIGNATURE OF PHYSICIAN</p>		<p>49. SIGNATURE OF CLERK</p>		<p>50. SIGNATURE OF JUDGE</p>	
<p>51. SIGNATURE OF DECEASED</p>		<p>52. SIGNATURE OF WITNESS</p>		<p>53. SIGNATURE OF PHYSICIAN</p>		<p>54. SIGNATURE OF CLERK</p>		<p>55. SIGNATURE OF JUDGE</p>	
<p>56. SIGNATURE OF DECEASED</p>		<p>57. SIGNATURE OF WITNESS</p>		<p>58. SIGNATURE OF PHYSICIAN</p>		<p>59. SIGNATURE OF CLERK</p>		<p>60. SIGNATURE OF JUDGE</p>	
<p>61. SIGNATURE OF DECEASED</p>		<p>62. SIGNATURE OF WITNESS</p>		<p>63. SIGNATURE OF PHYSICIAN</p>		<p>64. SIGNATURE OF CLERK</p>		<p>65. SIGNATURE OF JUDGE</p>	
<p>66. SIGNATURE OF DECEASED</p>		<p>67. SIGNATURE OF WITNESS</p>		<p>68. SIGNATURE OF PHYSICIAN</p>		<p>69. SIGNATURE OF CLERK</p>		<p>70. SIGNATURE OF JUDGE</p>	
<p>71. SIGNATURE OF DECEASED</p>		<p>72. SIGNATURE OF WITNESS</p>		<p>73. SIGNATURE OF PHYSICIAN</p>		<p>74. SIGNATURE OF CLERK</p>		<p>75. SIGNATURE OF JUDGE</p>	
<p>76. SIGNATURE OF DECEASED</p>		<p>77. SIGNATURE OF WITNESS</p>		<p>78. SIGNATURE OF PHYSICIAN</p>		<p>79. SIGNATURE OF CLERK</p>		<p>80. SIGNATURE OF JUDGE</p>	
<p>81. SIGNATURE OF DECEASED</p>		<p>82. SIGNATURE OF WITNESS</p>		<p>83. SIGNATURE OF PHYSICIAN</p>		<p>84. SIGNATURE OF CLERK</p>		<p>85. SIGNATURE OF JUDGE</p>	
<p>86. SIGNATURE OF DECEASED</p>		<p>87. SIGNATURE OF WITNESS</p>		<p>88. SIGNATURE OF PHYSICIAN</p>		<p>89. SIGNATURE OF CLERK</p>		<p>90. SIGNATURE OF JUDGE</p>	
<p>91. SIGNATURE OF DECEASED</p>		<p>92. SIGNATURE OF WITNESS</p>		<p>93. SIGNATURE OF PHYSICIAN</p>		<p>94. SIGNATURE OF CLERK</p>		<p>95. SIGNATURE OF JUDGE</p>	
<p>96. SIGNATURE OF DECEASED</p>		<p>97. SIGNATURE OF WITNESS</p>		<p>98. SIGNATURE OF PHYSICIAN</p>		<p>99. SIGNATURE OF CLERK</p>		<p>100. SIGNATURE OF JUDGE</p>	

621

50-10185

CERTIFICATE CORRECTED
CERTIFICATE CORRECTED

12-1-50

12-6-50

BALTIMORE CITY HEALTH DEPARTMENT

50-10185

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) (Harry) Henry W. Brighoff			2. DATE OF DEATH Nov. 28, 1950		
3. PLACE OF DEATH: a. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Maryland b. COUNTY 18-03		
5. FULL NAME OF HOSPITAL OR INSTITUTION 3301 Alto Road			c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore		
c. Length of stay in Baltimore Yrs. Mos. Days			o. STREET ADDRESS (If rural, give location) 1014 W. Lombard Street		
5. SEX male	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH 1883 Dec. 4, 1882		9. AGE (In years last birthday) 67 66
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Blacksmith		10B. KIND OF BUSINESS OR INDUSTRY B. & O. R. R. Co.	11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME William Brighoff			14. MOTHER'S MAIDEN NAME Marie Beck		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no		16. SOCIAL SECURITY NO. 705-03-9493	17. INFORMANT ADDRESS Mrs. Anita Brighoff, 1014 W. Lombard St.		

MEDICAL CERTIFICATION

18. 163X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH (A) Carcinoma of Lung DUE TO (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 1 Year AT LEAST
--	--	---	--	--

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from July 8, 1948, to Nov 28, 1950, that I last saw the deceased alive on Nov 28, 1950, and that death occurred at 7:45 p.m., from the causes and on the date stated above.					
23A. SIGNATURE Alfred Cole		23B. ADDRESS 136 A. Hilton ST		23C. DATE SIGNED Nov 28, 50	

24A. BURIAL, CREMATION, REMOVAL (Specify) burial	24B. DATE 12/1/50	24C. NAME OF CEMETERY OR CREMATORY Oak Lawn	24D. LOCATION (City, town, or county) (State) Baltimore Maryland
DATE RECEIVED BY LOCAL REGISTRAR NOV 29 1950		REGISTRAR'S SIGNATURE William H. Williams	25. FUNERAL DIRECTOR ADDRESS H. M. Cook, Inc. 1217 St. Paul Street

VS 150

501 50

47D

CONFIDENTIAL

CONFIDENTIAL

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CONFIDENTIAL

263
0-10186BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10186

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <i>Irvin, Reichard</i>		2. DATE OF DEATH <i>Nov. 28, 1950</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <i>Med Off 6</i>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md</i> B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>JOHNS HOPKINS HOSPITAL</i>		C. CITY OR TOWN (If outside corporate limits, write HURTLER and give township) <i>Baltimore 9-08</i>	
D. STREET ADDRESS (In rural, give location) <i>2000 Boone St</i>		5. SEX <i>male</i> 6. COLOR OR RACE <i>white</i> 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Single</i>	
c. Length of stay in Baltimore Yrs. Mos. Days		8. DATE OF BIRTH <i>7-17-03</i> 9. AGE (in years last birthday) <i>47</i> 10. Under 1 Year Months: Days 11. Under 24 Hours Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Mechanic</i>		10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Md</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>John Reichard</i>		14. MOTHER'S MAIDEN NAME <i>Cynthia Keeler</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>No</i> 16. SOCIAL SECURITY NO. <i>436-36-7985</i>		17. INFORMANT ADDRESS <i>JOHNS HOPKINS HOSPITAL</i>	

18. <i>4 yr. 2</i> CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) <i>Myocarditis</i> DUE TO		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Pneumonia</i>		

19A. DATE OF OPERATION <i>0</i>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDER- Lying <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *11/5* 10, 19*50*, to *11/28*, 19*50*, that I last saw the deceased alive on *11/28*, 19*50*, and that death occurred at *2* P. M., from the causes and on the date stated above.

23A. SIGNATURE <i>Reverend A. Saunders</i> M. D.		23B. ADDRESS <i>JOHNS HOPKINS HOSPITAL</i>		23C. DATE SIGNED <i>11/28/50</i>
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24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>12/2/50</i>	24C. NAME OF CEMETERY OR CREMATORY <i>Lorraine</i>	24D. LOCATION (City, town, or county) (State) <i>Balto. Co. Md.</i>
DATE RECEIVED BY LOCAL REGISTRAR <i>NOV 29 1950</i>		REGISTRAR'S SIGNATURE <i>William M. Williams</i>		25. FUNERAL DIRECTOR ADDRESS <i>Wm Cook Inc. 1217 St. Paul St.</i>

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100-1000

200
0-10187BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50-10187

1. NAME OF DECEASED (Type or Print) Jerome A. Weeks		2. DATE OF DEATH Nov. 27/50	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY 28-04	
B. FULL NAME OF (If not in hospital or institution, give street address or location) Colonial Nursing Home 4506 Frederick Ave.		C. CITY OR TOWN (If outside corporate limits, give RURAL and give township) Baltimore	
c. Length of stay in Baltimore Life		D. STREET ADDRESS (If rural, give location) 4506 Frederick Ave.	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH Sept. 30, 1883
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired, Mobile Trailer Operator		9. AGE (In year: last birthday) 67 If Under 1 Year: Months: Days If Under 24 Hours: Hours: Min.	
10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Balto. Md.	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME Henry Weeks	
14. MOTHER'S MAIDEN NAME Achsah Ensor		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	
16. SOCIAL SECURITY NO. 212 18 3008		17. INFORMANT ADDRESS Robert P. Manning, 323 Marydell Rd.	
18. 163 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Carcinoma Right Lung (A) DUE TO Thrombosis (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 6 mos. 1 mo.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION unknown (J.H.H.)		19B. MAJOR FINDINGS OF OPERATION Carcinoma Right Lung	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	
21C. TIME (Month) (Day) (Year) (Hour) OF INJURY		21D. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 11-15 , 19 50 , to 11-27 , 19 50 , that I last saw the deceased alive on 11-27 , 19 50 , and that death occurred at 9:45 p. m., from the causes and on the date stated above.			
23A. SIGNATURE William L. Deenitz		23B. ADDRESS 3025 Belair Rd	
23C. DATE SIGNED 11-28-50			
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE Nov. 30/50	
24C. NAME OF CEMETERY OR CREMATORY St. Vincent's Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
DATE RECEIVED BY LOCAL REGISTRAR NOV 29 1950		REGISTRAR'S SIGNATURE Harry J. W. White	
25. FUNERAL DIRECTOR 4101 Edmondson Ave.		ADDRESS	

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Jarvis W. Jarvis

501 Broadway Ave.

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J.H.H.

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520
50-10188
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10188
Registered No.

1. NAME OF DECEASED (Type or Print) ADAM LEHNEIS			2. DATE OF DEATH Nov. 28, 1950		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY		
B. FULL NAME OF HOSPITAL OR INSTITUTION Beech Hill Conv. Home			C. CITY OR TOWN (If outside corporate limits, give RURAL and give township) Baltimore		
c. Length of stay in Baltimore life			D. STREET ADDRESS (If rural, give location) 518 N. Streeper St.		
5. SEX male	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) widowed	8. DATE OF BIRTH June 4, 1876	9. AGE (In years last birthday) 74	10. Under 1 Year Months: Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired - solderer			11. BIRTHPLACE (State or foreign country) Baltimore, Md.		
10B. KIND OF BUSINESS OR INDUSTRY Cont. Can Co.			12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME unknown			14. MOTHER'S MAIDEN NAME unknown		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
17. INFORMANT Mrs. Mildred Grubert, dght.			ADDRESS 3005 Arizona Ave.		

18. 161X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CARCINOMA, LARYNX			INTERVAL BETWEEN ONSET AND DEATH 6 Mos.
DUE TO (A)			
DUE TO (B)			
DUE TO (C)			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Arteriosclerosis Generalized.			3 years.
19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 3/18/1950 , to 11/27/50 , 19 50 , that I last saw the deceased alive on 11/27 , 19 50 , and that death occurred at 4:45 a.m., from the causes and on the date stated above.			
23A. SIGNATURE Benj. B. Moore, M.D.	23B. ADDRESS 448 N. Luzerne Ave.	23C. DATE SIGNED 11/28/50	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial	24B. DATE 12/1/50	24C. NAME OF CEMETERY OR CREMATORY Parkwood Cem.	24D. LOCATION (City, town, or county) (State) 3310 Taylor Ave., Balto. Md.
DATE RECEIVED BY LOCAL REGISTRAR NOV 29 1950	REGISTRAR'S SIGNATURE William M. Williams	25. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. 2601-3-5 E. Madison St.	

MEDICAL CERTIFICATION

50-10108

UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION

10-10108

[Faint, mostly illegible text covering the body of the document, likely a memorandum or report. The text is too light to transcribe accurately.]

243
0-10189

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10189

Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED (Type or Print) <i>Rose Besold</i>		2. DATE OF DEATH <i>11/27/50</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY _____	
B. FULL NAME OF (If not in hospital or institution, give street address or location) <i>Mercy Hospital</i>		C. CITY OR TOWN (If outside corporate limits, give RURAL and give township) <i>Baltimore</i> <i>2-01</i>	
c. Length of stay in Baltimore <i>67</i> Yrs. <i>X</i> Mths. <i>X</i> Days		D. STREET ADDRESS (If rural, give location) <i>217 S. Wolfe St.</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>Wht</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>WIDOWED</i>	8. DATE OF BIRTH <i>1/25/78</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>at home</i>	9. AGE (In years last birthday) <i>72</i>
11. BIRTHPLACE (State or foreign country) <i>Prague, Czech.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Joseph LERRE</i>		14. MOTHER'S MAIDEN NAME <i>Marie KALIVODA</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <i>no</i>	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS <i>Anna Walls 2814 E. Chase St.</i>

CAUSE OF DEATH

18. <i>260 X</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) <i>Mesenteric Vascular Occlusion</i> DUE TO	INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B) <i>Generalized Arteriosclerosis</i> DUE TO	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	(C) <i>Diabetes Mellitus</i>	

19A. DATE OF OPERATION <i>2</i>	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED m. WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *11/19, 1950*, to *11/27, 1950*, that I last saw the deceased alive on *11/27, 1950*, and that death occurred at *12 1/2* m., from the causes and on the date stated above.

23A. SIGNATURE <i>Paul F. Richardson</i> M. D.	23B. ADDRESS <i>Mercy Hosp.</i>	23C. DATE SIGNED <i>11/27/50</i>
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24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>Nov. 30, 1950</i>	24C. NAME OF CEMETERY OR CREMATORY <i>Jerusalem Cemetery</i>	24D. LOCATION (City, town, or county) (State) <i>Belair Rd., Baltimore, Md.</i>
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DATE RECEIVED BY LOCAL REGISTRAR <i>NOV 29 1950</i>	REGISTRAR'S SIGNATURE <i>Wm. H. Williams, Jr.</i>	25. FUNERAL DIRECTOR <i>Schimunek Funeral Home, Inc.</i> 2601-3-5 E. Madison St.
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MEDICAL CERTIFICATION

TO THE SECRETARY OF THE INTERIOR
FROM THE DIRECTOR OF THE BUREAU OF LAND MANAGEMENT
SUBJECT: [Illegible]

[The following text is extremely faint and largely illegible due to the quality of the scan. It appears to be a memorandum or report detailing land management activities, possibly related to a specific project or area. Key words that are faintly visible include "land", "management", "project", "area", "survey", "map", "plan", "order", "request", "information", "data", "records", "files", "documents", "maps", "plans", "orders", "requests", "information", "data", "records", "files", "documents".]

530
50-10190
BIRTH NO.BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50-10190

1. NAME OF DECEASED (Type or Print) ANNA JANDA		2. DATE OF DEATH Nov. 27, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland 703 N. Milton Ave.		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE Md. B. COUNTY	
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore	
c. Length of stay in Baltimore 39 yrs.		D. STREET ADDRESS (If rural, give location) 703 N. Milton Ave.	
5. SEX female	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH June 27, 1883
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10B. KIND OF BUSINESS OR INDUSTRY at home	9. AGE (In years; last birthday) 67
11. BIRTHPLACE (State or foreign country) Czechoslovakia		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME John Stodulka		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Louis Janda, husband, above		ADDRESS	
18. 260X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH Diabetic Coma DUE TO Diabetes Mellitus INTERVAL BETWEEN ONSET AND DEATH 11/17/50 Jan 1. 46			
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Oct 30, 1950, to Nov 27, 1950, that I last saw the deceased alive on Nov 27, 1950, and that death occurred at 9:30 pm., from the causes and on the date stated above.			
23A. SIGNATURE William J. Rydman		23B. ADDRESS 801 W 11thwoodth	
23C. DATE SIGNED 11/28/50			
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-30-50	
24C. NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery		24D. LOCATION (City, town, or county) (State) Horner's Lane, Balto. Md.	
DATE RECEIVED BY LOCAL REGISTRAR NOV 29 1950		REGISTRAR'S SIGNATURE [Signature]	
25. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. 2601-3-5 E. Madison St.		ADDRESS	

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CENTRAL OF DEATH

00101-00



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50-10192

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50-10192

1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH	
MARIE FARBER ELEY		Nov. 28 - 50	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY BALTO.	
B. FULL NAME OF HOSPITAL OR INSTITUTION 326 PADDINGTON RD.		C. CITY OR TOWN BALTO.	
c. Length of stay in Baltimore LIFE		D. STREET ADDRESS (If rural, give location) 326 PADDINGTON RD.	
5. SEX F	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED	8. DATE OF BIRTH SEPT. 5, 1876
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (in years last birthday) 74
13. FATHER'S NAME HENRY J. FARBER		11. BIRTHPLACE (State or foreign country) MD.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT MRS. J. M. TRAVIS		12. CITIZEN OF WHAT COUNTRY? SAME	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) 157X I CANCER - HEAD OF PANCREAS		INTERVAL BETWEEN ONSET AND DEATH SEPT 1950	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 1946, 19, to 11-27, 1950, that I last saw the deceased alive on 11-26, 1950, and that death occurred at 2:00 p.m., from the causes and on the date stated above.			
23A. SIGNATURE Walter E. Baylis		23B. ADDRESS 4331 Harford Rd	
23C. DATE SIGNED 11/28/50			
24A. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 11-30-1950	
24C. NAME OF CEMETERY OR CREMATORY LOUDON PARK		24D. LOCATION (City, town, or county) (State) BALTO. MD.	
DATE RECEIVED BY LOCAL REGISTRAR NOV 29 1950		25. FUNERAL DIRECTOR H. W. JENKINS & SONS 4905 YORK RD.	

MEDICAL CERTIFICATION

DR W.E. KARFGIN

4331 HARFORD RD

240
50-10193
BIRTH NO.BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10193

Registered No.

1. NAME OF DECEASED (Type or Print) William Brinton McCauley		2. DATE OF DEATH 11-28-1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY Baltimore	
B. FULL NAME OF HOSPITAL OR INSTITUTION 2125 Lyndhurst Ave.,		C. CITY OR TOWN (If outside corporate limits, write R.U.R. and give township) Baltimore	
c. Length of stay in Baltimore 65- Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) 2125 Lyndhurst Ave.,	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Nov. 17, 1887
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sales Engineer		10B. KIND OF BUSINESS OR INDUSTRY Standard Conveyor Co.	9. AGE (In years, last birthday) 63
13. FATHER'S NAME William B. McCauley		12. CITIZEN OF WHAT COUNTRY? Md.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no		14. MOTHER'S MAIDEN NAME Norris	
16. SOCIAL SECURITY NO. none		17. INFORMANT ADDRESS Mrs. Audrey A. McCauley 2125 Lyndhurst	
18. 177X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) Coronary Thrombosis 4 hours DUE TO (B) Atherosclerosis years DUE TO (C) Carcinoma of Prostate 6-18 mos INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION 11/10/50		19B. MAJOR FINDINGS OF OPERATION Carcinoma of prostate invading bladder	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) none		21B. PLACE OF INJURY (If in Baltimore City, give exact location) none	
21C. WHERE DID INJURY OCCUR? none			
21D. TIME (Month) (Day) (Year) (Hour) INJURY X		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR? X			
22. I hereby certify that I attended the deceased from 11/2/50, 19, to 11/28/50, 19, that I last saw the deceased alive on 11/22, 19, 50, and that death occurred at home, from the causes and on the date stated above.			
23A. SIGNATURE Mark Skinsong		23B. ADDRESS 18 E. Eager St	
23C. DATE SIGNED 11/28/50			
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-30-1950	
24C. NAME OF CEMETERY OR CREMATORY Woodlawn		24D. LOCATION (City, town, or county) (State) Woodlawn, Md.	
DATE RECEIVED BY LOCAL REGISTRAR NOV 29 1950		25. FUNERAL DIRECTOR ADDRESS G. Howard Strong 3207 W. North Ave.,	

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8-15-42

Dr. F.W. Stinson Jr

18E. Eager St

**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

50-10194

Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED (Type or Print) Kulinski (Collins), Frank		2. DATE OF DEATH November 27, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 26-10	
B. FULL NAME OF (If not in hospital or institution, give street address or location) St. Joseph's		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore	
c. Length of stay in Baltimore Life		D. STREET ADDRESS (If rural, give location) 3242 E. Balto. St.	
5. SEX M.	6. COLOR OR RACE W.	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH July 7, 1894
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician		10B. KIND OF BUSINESS OR INDUSTRY Unemployed	9. AGE (In years last birthday) 56
13. FATHER'S NAME Michael Kulinski		11. BIRTHPLACE (State or foreign country) Baltimore	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
16. SOCIAL SECURITY NO. 213-03-3439		17. INFORMANT ADDRESS Anna Kulinski 3242 E. Balto. St.	

18. 137X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Pericarditis		INTERVAL BETWEEN ONSET AND DEATH
DUE TO		
(A) Multiple Lung Abscess		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Aedimycosis bovis		
DUE TO		
(B) Multiple Lung Abscess		
DUE TO		
(C) Aedimycosis bovis		

19A. DATE OF OPERATION Oct. 17, 1950		19B. MAJOR FINDINGS OF OPERATION Pleuritis, Chronic; Cellulitis, Chronic		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from **September 18 1950** to **November 27 1950**, that I last saw the deceased alive on **Nov. 27, 1950**, and that death occurred at **8:40 p.m.**, from the causes and on the date stated above.

23A. SIGNATURE <i>William B. Decker</i>		23B. ADDRESS M. D. 1100 N. Caroline St.		23C. DATE SIGNED Nov. 27, 1950	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE Dec. 1-50		24C. NAME OF CEMETERY OR CREMATORY St. Stanislaus	
24D. LOCATION (City, town, or county) (State) Balto. City Md.		25. FUNERAL DIRECTOR Wm. S. Fialkowski		ADDRESS 2007 Eastern Ave	
DATE RECEIVED BY LOCAL REGISTRAR NOV 29 1950		REGISTRAR'S SIGNATURE <i>William B. Decker</i>			

CERTIFICATE OF DEATH

10101-1	
DATE OF DEATH	
PLACE OF DEATH	
CAUSE OF DEATH	
MANNER OF DEATH	
AGE	
SEX	
RACE	
RELIGION	
EDUCATION	
OCCUPATION	
MARRIAGE	
CHILDREN	
SPOUSE	
FAMILY	
SOCIAL	
ECONOMIC	
POLITICAL	
CULTURAL	
RECREATION	
HEALTH	
MENTAL	
PHYSICAL	
EMOTIONAL	
SPIRITUAL	
ENVIRONMENTAL	
SOCIAL	
ECONOMIC	
POLITICAL	
CULTURAL	
RECREATION	
HEALTH	
MENTAL	
PHYSICAL	
EMOTIONAL	
SPIRITUAL	
ENVIRONMENTAL	

335
0-10195BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50-10195
Registered No.

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Mrs Margaret Stidham</i>		2. DATE OF DEATH <i>11/28/50</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY			
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>St Agnes Hospital</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore</i>			
c. Length of stay in Baltimore		D. STREET ADDRESS (If rural, give location) <i>711 Elm Allen Dr</i>			
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH <i>6-25-81</i>	9. AGE (in years last birthday) <i>69</i>	10. Under 1 Year Months: Days 11. Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Clark</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Balti. Transit STREET RAILWAY</i>		11. BIRTHPLACE (State or foreign country) <i>Mo.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>Alexander</i>		14. MOTHER'S MAIDEN NAME <i>Susan Deik</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Alphina G. Stidham</i> ADDRESS <i>711 Elm Allen Dr</i>	
18. <i>570.5</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>CHOLEMIA</i> DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <i>INTESTINAL OBSTRUCTION</i> DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>12/1/50</i>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>11/25, 1950</i> to <i>11/28, 1950</i> , that I last saw the deceased alive on <i>11/28, 1950</i> , and that death occurred at <i>2:30 AM.</i> , from the causes and on the date stated above.					
23A. SIGNATURE <i>John H. Shaw</i> M. O.		23B. ADDRESS <i>St. Agnes Hosp</i>		23C. DATE SIGNED <i>11/28/50</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>12/1/50</i>		24C. NAME OF CEMETERY OR CREMATORY <i>LOUDON PARK</i>	
24D. LOCATION (City, town, or county) <i>Baltimore</i>		24E. DATE RECEIVED BY LOCAL REGISTRAR		24F. REGISTRAR'S SIGNATURE <i>Thurston Williams</i>	
24G. DATE RECEIVED BY LOCAL REGISTRAR		24H. REGISTRAR'S SIGNATURE		24I. FUNERAL DIRECTOR <i>M. FAHEY & SONS</i>	
24J. ADDRESS		24K. ADDRESS		24L. ADDRESS	

MEDICAL CERTIFICATION

NOV 29 1950
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520 50-10196 CERTIFICATE CORRECTED 12-12-50									
BALTIMORE CITY HEALTH DEPARTMENT									
CERTIFICATE OF DEATH									
Registered No. 50-10196									
BIRTH NO.									
1. NAME OF DECEASED (Type or Print) William JAMES					2. DATE OF DEATH Nov. 28, 1950				
3. PLACE OF DEATH: A. Baltimore City, Maryland					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY				
B. FULL NAME OF HOSPITAL OR INSTITUTION Baltimore City Hospital					C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore				
D. STREET ADDRESS (If rural, give location) 1321 N. Bond St.									
E. Length of stay in Baltimore									
5. SEX Male		6. COLOR OR RACE Colored		7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH Jan 28, 1888		9. AGE (In years last birthday) 62	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clergyman		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Richmond Va.			12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME William James					14. MOTHER'S MAIDEN NAME Harriett				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO.		17. INFORMANT Ruth M. James 1321 N. Bond St.		
18. 443 X and E 90 DUE TO CAUSE OF DEATH									
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)									
(A) Hypertensive Cardiovascular Disease									
DUE TO									
ANTECEDENT CAUSES									
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.									
(B)									
DUE TO									
(C)									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Fracture of pelvis and left femur									
19A. DATE OF OPERATION					19B. MAJOR FINDINGS OF OPERATION				
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Hospital			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Baltimore City Hospital 26/12			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY Oct. 31, 1950 6 P.m.			21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21F. HOW DID INJURY OCCUR? Fell from hospital window to roof-12'			
22. I certify that I took charge of the remains described above, held an Inspection & Inq. thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> accident <input checked="" type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/> .									
23A. SIGNATURE William V. Lovett					23B. CHIEF MEDICAL EXAMINER..... M.D. ASSISTANT MEDICAL EXAMINER..... MEDICAL INVESTIGATOR.....				
23C. DATE SIGNED Nov. 28, 1950									
24A. BURIAL, CREMATION, REMOVAL (Specify) Removal		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY Lincoln Mem. Cemetery Washington D.C.		24D. LOCATION (City, town, or county) (State) Washington D.C.			
DATE RECEIVED BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR Mrs. Ernest G. Edister, Daughter		ADDRESS			
NOV 29 1950 VS 151 0098W 1860 1/2 977 N. Caroline ST.									

30-1-106

30-1-106

DEATH STATE OF OHIO



200
50-10197BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50-10197

BIRTH NO.

1. NAME OF DECEASED (Type or Print) GEORGIANNA HOUSE		2. DATE OF DEATH Nov 26 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission) A. STATE MD B. COUNTY Baltimore	
B. FULL NAME OF HOSPITAL OR INSTITUTION 438 W Conway		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore	
c. Length of stay in Baltimore 62 Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) 438 W Conway	
5. SEX Female	6. COLOR OR RACE Col-	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widow	8. DATE OF BIRTH Aug 15 1893
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) house		9. AGE (In years last birthday) 77	
10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia	
13. FATHER'S NAME John Bailey		12. CITIZEN OF WHAT COUNTRY?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		14. MOTHER'S MAIDEN NAME Leah Bailey	
16. SOCIAL SECURITY NO.		17. INFORMANT Wilhelm Henry ADDRESS 438 W Conway	

18. 446 X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Cerebral Hemorrhage DUE TO My peterson neglect	CAUSE OF DEATH	INTERVAL BETWEEN ONSET AND DEATH 3 wks
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 11/15, 1950 , to 11/26, 1950 , that I last saw the deceased alive on 11/25, 1950 , and that death occurred at 7:20 a.m. , from the causes and on the date stated above.					
23A. SIGNATURE Dr. J. L. Brown		23B. ADDRESS 108 W		23C. DATE SIGNED 11/26/50	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/30/50		24C. NAME OF CEMETERY OR CREMATORY Mt Auburn	
24D. LOCATION (City, town, or county) (State) Balto City		25. FUNERAL DIRECTOR J. L. Brown & Son - Montgomery St			
DATE RECEIVED BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE W. J. ...		ADDRESS 108 W	

NOV 28 1950

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100-1000

DEPARTMENT OF DEATH

100-1000



536
50-10198
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10198
Registered No.

1. NAME OF DECEASED (Type or Print) Samuel ANDERSON			2. DATE OF DEATH Nov. 27, 1950		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY		
B. FULL NAME OF HOSPITAL OR INSTITUTION University Hospital			C. CITY OR TOWN (If outside corporate limits, write "RURAL" and give township) Baltimore		
C. Length of stay in Baltimore			D. STREET ADDRESS (If rural, give location) 648 W. Fayette St.		
5. SEX Male	6. COLOR OR RACE Colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 1883	9. AGE (In years last birthday) 67	10. Under 1 Year Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer - property sales			11. BIRTHPLACE (State or foreign country) unknown		
10B. KIND OF BUSINESS OR INDUSTRY REAL ESTATE			12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME Thomas Anderson			14. MOTHER'S MAIDEN NAME unknown		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. 219-01-5421		
			17. INFORMANT Mary Goodman 1406 Harlem Ave		

18. 443 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Hypertensive Cardiovascular Disease (A) DUE TO	INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES (B) DUE TO	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (C) DUE TO	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	

22. I certify that I took charge of the remains described above, held an INSPECTION & Inq. thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE William L. [Signature]		23B. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> MEDICAL INVESTIGATOR <input type="checkbox"/>		23C. DATE SIGNED Nov. 27, 1950	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial	24B. DATE 11/30/50	24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem.	24D. LOCATION (City, town, or county) (State) West Port Balto. Md.		
DATE RECEIVED BY LOCAL REGISTRAR NOV 29 1950		REGISTRAR'S SIGNATURE [Signature]		25. FUNERAL DIRECTOR Metropolitan Funeral Home Inc.	

V.S. 1st. 97074 925 927. N. Mount

MEDICAL CERTIFICATION

346
0-10199
BIRTH NO.BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50-10199
Registered No.

1. NAME OF DECEASED (Type or Print) <i>Malachi Butler.</i>		2. DATE OF DEATH <i>November 25, 1950.</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>1077 W. Fayette St.</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore 18-00</i>	
C. Length of stay in Baltimore <i>Life</i>		D. STREET ADDRESS (If rural, give location) <i>1077 W. Fayette St.</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>C</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>married</i>	8. DATE OF BIRTH <i>March 19, 1897</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Laborer</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Junk dealer</i>	9. AGE (In years - last birthday) <i>53</i>
11. BIRTHPLACE (State or foreign country) <i>Baltimore, Md.</i>		12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>	
13. FATHER'S NAME <i>Lambert Butler.</i>		14. MOTHER'S MAIDEN NAME <i>Ella Giles.</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <i>No</i>		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Mrs. Florence Butler.</i>		ADDRESS <i>1077 W. Fayette St.</i>	

18. <i>490X</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Lobar Pneumonia</i>	CAUSE OF DEATH (A) <i>Lobar Pneumonia</i> DUE TO (B) _____ DUE TO (C) _____	INTERVAL BETWEEN ONSET AND DEATH <i>2 weeks</i>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION <i>11-29-1950</i>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>11/18</i> , 1950, to <i>11/25</i> , 1950, that I last saw the deceased alive on <i>11/18</i> , 1950, and that death occurred at <i>11 A.M.</i> , from the causes and on the date stated above.					
23A. SIGNATURE <i>Ralph W. Neill</i>		23B. ADDRESS <i>445 N. Guilford St.</i>		23C. DATE SIGNED <i>11/28/50</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>11-29-1950</i>		24C. NAME OF CEMETERY OR CREMATORY <i>W. H. Mumferson Cem.</i>	
24D. LOCATION (City, town, or county) <i>Balto.</i>		24E. STATE <i>Md.</i>		24F. FUNERAL DIRECTOR <i>Mrs. Marie R. Williams</i>	
24G. ADDRESS <i>91 Schroeder St.</i>		24H. DATE RECEIVED BY LOCAL REGISTRAR <i>NOV 29 1950</i>		24I. REGISTRAR'S SIGNATURE <i>W. H. Mumferson</i>	

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RECEIVED

1941

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50-10200

REA-139670

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50-10200

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Russell Smith		2. DATE OF DEATH Nov. 25, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY	
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION Baltimore City Hospitals 4940 Eastern Avenue		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore	
c. Length of stay in Baltimore 36 yrs. Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) 717 Pen Ally (Alley) Pin?	
5. SEX Male	6. COLOR OR RACE Negro	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH July 21, 1908
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10B. KIND OF BUSINESS OR INDUSTRY General	9. AGE (In years last birthday) 42 If Under 1 Year: Months: Days If Under 24 Hours: Hours: Min.
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME William Smith		14. MOTHER'S MAIDEN NAME Carrie Lawson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Records: B. C. H.		ADDRESS 4940 Eastern Avenue	

18. 203X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Multiple Myeloma (A) DUE TO	INTERVAL BETWEEN ONSET AND DEATH 1 Year
ANTECEDENT CAUSES (B) DUE TO	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (C) DUE TO	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Cachexia	2 Months

19A. DATE OF OPERATION 7-11-50	19B. MAJOR FINDINGS OF OPERATION Biopsy of Thigh	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **7-12-50**, 19**50**, to **11-25**, 19**50**, that I last saw the deceased alive on **11-25**, 19**50**, and that death occurred at **11:45A** m., from the causes and on the date stated above.

23A. SIGNATURE <i>P. S. Boyer</i> M. D.	23B. ADDRESS 4940 Eastern Avenue	23C. DATE SIGNED 11-28-50
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24A. BURIAL, CREMATION, REMOVAL (Specify) Burial	24B. DATE 12-1-1950	24C. NAME OF CEMETERY OR CREMATORY W. M. Auburn Cem	24D. LOCATION (City, town, or county) (State) Balto. Md
DATE RECEIVED BY LOCAL REGISTRAR NOV 23 1950	REGISTRAR'S SIGNATURE <i>W. M. Auburn</i>	25. FUNERAL DIRECTOR Mrs. Katie R. Williams	ADDRESS 8224 Schroeder St

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425
50-10201

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10201

Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED (Type or Print) WATSON FALCON		2. DATE OF DEATH Nov. 27, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY _____	
B. FULL NAME OF HOSPITAL OR INSTITUTION US Marine Hospital Wyman Pk. Drive & 31st St.		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore	
D. STREET ADDRESS (If rural, give location) 785 W. Saratoga St.			
5. SEX M		6. COLOR OR RACE col	
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH 4/16/97	
9. AGE (In years last birthday) 53		10. Under 1 Year: Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10B. KIND OF BUSINESS OR INDUSTRY STEVEDORE	
11. BIRTHPLACE (State or foreign country) NC		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Albert Falcon		14. MOTHER'S MAIDEN NAME Annie King	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Yes		16. SOCIAL SECURITY NO. WW I	
17. INFORMANT Records- US Marine Hospital, Balto, Md.		ADDRESS	

18. 442X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Nephrosclerosis with hypertension, cardiac hypertrophy, pulmonary edema and uremia		INTERVAL BETWEEN ONSET AND DEATH Unknown
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		
19A. DATE OF OPERATION Nov. 27, 1950	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from Nov. 24 , 19 50 , to Nov. 27 , 19 50 , that I last saw the deceased alive on Nov. 27, 1950 , and that death occurred at _____ m., from the causes and on the date stated above.		
23A. SIGNATURE D.W. Patrick, Medical Officer in Charge	23B. ADDRESS US Marine Hospital, Balto, Md.	23C. DATE SIGNED 11/27/50
24A. BURIAL, CREMATION, REMOVAL (Specify) buried	24B. DATE 12-1-1950	24C. NAME OF CEMETERY OR CREMATORY Northline P.C. Northline P.C.
24D. LOCATION (City, town, or county) (State) N.C.	25. FUNERAL DIRECTOR Mr. Kate Williams	ADDRESS 322 N. Schenck St.

MEDICAL CERTIFICATION

NOV 29 1950

VS 150

940 55

131a

100-10000

STATE OF NEW YORK

CERTIFICATE OF DEATH

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252
50-10202

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50-10202

BIRTH NO.

1. NAME OF DECEASED (Type or Print) OLIVER HAWKINS		2. DATE OF DEATH November 26, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY	
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION Provident Hospital		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore	
C. Length of stay in Baltimore		D. STREET ADDRESS (If rural, give location) 2243 Brunt Street	
5. SEX male	6. COLOR OR RACE colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH May 6, 1920
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
13. FATHER'S NAME Herbert Hawkins		14. MOTHER'S MAIDEN NAME Mary E. Ebbs	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) YES		16. SOCIAL SECURITY NO. W.W. II	
17. INFORMANT Mary Hawkins		ADDRESS 2243 Brunt St	

18. 353.3 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Epilepsy (A) DUE TO	CAUSE OF DEATH	INTERVAL BETWEEN ONSET AND DEATH
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		
19A. DATE OF OPERATION		
19B. MAJOR FINDINGS OF OPERATION		
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		

21A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Inquiry & Inspection thereon and from Autopsy, Inspection or Inquiry the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE William V. Williams		23B. CHIEF MEDICAL EXAMINER..... M.D. ASSISTANT MEDICAL EXAMINER..... MEDICAL INVESTIGATOR.....		23C. DATE SIGNED Nov. 27, 1950	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial	24B. DATE 12-1-1950	24C. NAME OF CEMETERY OR CREMATORY Balto. National	24D. LOCATION (City, town, or county) Balto.	(State) Md.	
DATE RECEIVED BY LOCAL REGISTRAR NOV 29 1950		REGISTRAR'S SIGNATURE William V. Williams, M.D.		25. FUNERAL DIRECTOR Mrs. Kate R. Williams	
				ADDRESS 322 N. Schuyler St	

525
10-10203

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10203
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Walter Johnson		2. DATE OF DEATH November 27, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE md. B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION JONKS HOPKINS HOSPITAL		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore	
c. Length of stay in Baltimore		D. STREET ADDRESS (If rural, give location) 623 S. Dunham St.	
5. SEX male	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH 3-31-97
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MECHANIC		9. AGE (In years last birthday) 53	
10B. KIND OF BUSINESS OR INDUSTRY AMERICAN Cans Co.		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME William Johnson		12. CITIZEN OF WHAT COUNTRY?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		14. MOTHER'S MAIDEN NAME ?	
16. SOCIAL SECURITY NO. 407-09-2300		17. INFORMANT JONKS HOPKINS HOSPITAL	
		ADDRESS	

18. **443 X I**
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
Cerebral vascular accident
DUE TO
ANTECEDENT CAUSES
Hypertensive cardiovascular disease
DUE TO
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(C)

INTERVAL BETWEEN ONSET AND DEATH

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED m. WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from **11-27** 19**50**, to **11-27** 19**50**, that I last saw the deceased alive on **11-27** 19**50**, and that death occurred at **7:00 P.M.**, from the causes and on the date stated above.

23A. SIGNATURE William C. Barandell M. D.	23B. ADDRESS JONKS HOPKINS HOSPITAL	23C. DATE SIGNED 11/28/50
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24A. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	24B. DATE NOV. 29-1950	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State) CATLETTSBURG, KENTUCKY
DATE RECEIVED BY LOCAL REGISTRAR NOV 29 1950		REGISTRAR'S SIGNATURE William C. Barandell	25. FUNERAL DIRECTOR George A. Weber 705 - S Ann st

VS 150

J.A. BARANDOLL

55430

93D

MEDICAL CERTIFICATION

1002

10-11

003-82091 4-10-20

536
50-10204
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10204

Registered No. _____

1. NAME OF DECEASED (Type or Print) <u>Myrtle Margaret Schneider</u>			2. DATE OF DEATH <u>Nov. 26, 1950</u>		
3. PLACE OF DEATH: A. Baltimore City, Maryland <u>Baltimore</u>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY _____		
B. FULL NAME OF HOSPITAL OR INSTITUTION <u>616 S. Ellwood Ave.</u>			C. CITY OR TOWN (If outside corporate limits, write P.O. and give township) <u>Baltimore</u>		
c. Length of stay in Baltimore <u>Life</u>			D. STREET ADDRESS (If rural, give location) <u>616 S. Ellwood Ave.</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>March 21, 1893</u>	9. AGE (In years last birthday) <u>57</u>	10. Under 1 Year Months: Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10B. KIND OF BUSINESS OR INDUSTRY -----		
13. FATHER'S NAME <u>William M. Jenkins</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) -----			16. SOCIAL SECURITY NO. -----		
17. INFORMANT <u>William N. Schneider</u>			ADDRESS <u>616 S. Ellwood Ave.</u>		

18. <u>171X</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) <u>myocardial Decompensation</u> DUE TO ANTECEDENT CAUSES (B) <u>myocarditis</u> DUE TO <u>Carcinoma of Cervix</u> (C) _____	INTERVAL BETWEEN ONSET AND DEATH
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19A. DATE OF OPERATION <u>9</u>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Sept 30, 1950</u> , to <u>Nov 26, 1950</u> , that I last saw the deceased alive on <u>Nov 26, 1950</u> , and that death occurred at <u>6:30 p.m.</u> , from the causes and on the date stated above.					
23A. SIGNATURE <u>L. A. Fleming Jr.</u>		23B. ADDRESS <u>3501 Fair Ave</u>		23C. DATE SIGNED <u>11-28-50</u>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>11/29/50</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Oakland Cem.</u>	
				24D. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	

DATE RECEIVED BY LOCAL REGISTRAR <u>NOV 29 1950</u>		REGISTRAR'S SIGNATURE <u>William M. Jenkins</u>		25. FUNERAL DIRECTOR <u>John D. Morgan</u>	
				ADDRESS <u>3000 E. Baltimore St.</u>	

VS 150

48a

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10205

Registered No.

1. NAME OF DECEASED
(Type or Print)

Alexander (Mon) Monkievics, Sr.

2. DATE
OF
DEATH

Nov 27th 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland 2326 E Federal St

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Md

B. FULL NAME OF HOSPITAL OR INSTITUTION

C. CITY OR TOWN (If outside corporate limits, write R.R.A. and give township)

Balto

D. STREET ADDRESS (If rural, give location)

2326 E. Federal St

c. Length of stay in Baltimore

50

Yrs.
Mos.
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

Sept 19th 1860

9. AGE (In years last birthday)

90

11 Under 1 Year Months: Days

11 Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Machinist

10B. KIND OF BUSINESS OR INDUSTRY

Monitor Controller

11. BIRTHPLACE (State or foreign country)

Rega Lithua Lithuania

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Alexander Monkievics

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

16. SOCIAL SECURITY NO.

17. INFORMANT

MON, Jr.

ADDRESS

2326 E. Federal St

18. 4221 I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

Arterio Sclerosis Cerebro Vascular Disease approx 4 min

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 17 May, 1950, to 27 Nov, 1950, that I last saw the deceased alive on 27 Nov, 1950, and that death occurred at 9:45 p.m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

Burial

Nov 27 1950

Holy Redeemer

Belair Road

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

NOV 29 1950

William H. Williams, M.D.

Leo S. Cook 170103 N. Patterson Park Ave

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[Faint, illegible handwriting throughout the page, likely bleed-through from the reverse side. The text is too light to transcribe accurately.]

530

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10206

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <i>Stella Smith</i>			2. DATE OF DEATH <i>Nov. 28 1950</i>		
3. PLACE OF DEATH: A. Baltimore City, Maryland <i>1200 Valley St</i>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Baltimore</i> B. COUNTY <i>Maryland</i>		
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>Little Sisters of the Poor</i>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore</i>		
C. Length of stay in Baltimore			D. STREET ADDRESS (If rural, give location) <i>1200 Valley St.</i>		
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Black</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Widow</i>	8. DATE OF BIRTH <i>June 16, 1872</i>		9. AGE (In years last birthday) <i>78</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY <i>Housework</i>	11. BIRTHPLACE (State or foreign country) <i>Columbia Pa</i>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <i>Peter Mandawney</i>			14. MOTHER'S MAIDEN NAME <i>Martha Trusty</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS		

18. <i>442X</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	CAUSE OF DEATH (A) <i>Hypertensive Cardio-Renal Disease</i> DUE TO	INTERVAL BETWEEN ONSET AND DEATH <i>1 yr</i>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B) <i>Arterio Sclerosis</i> DUE TO	<i>5 yrs</i>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	(C)	

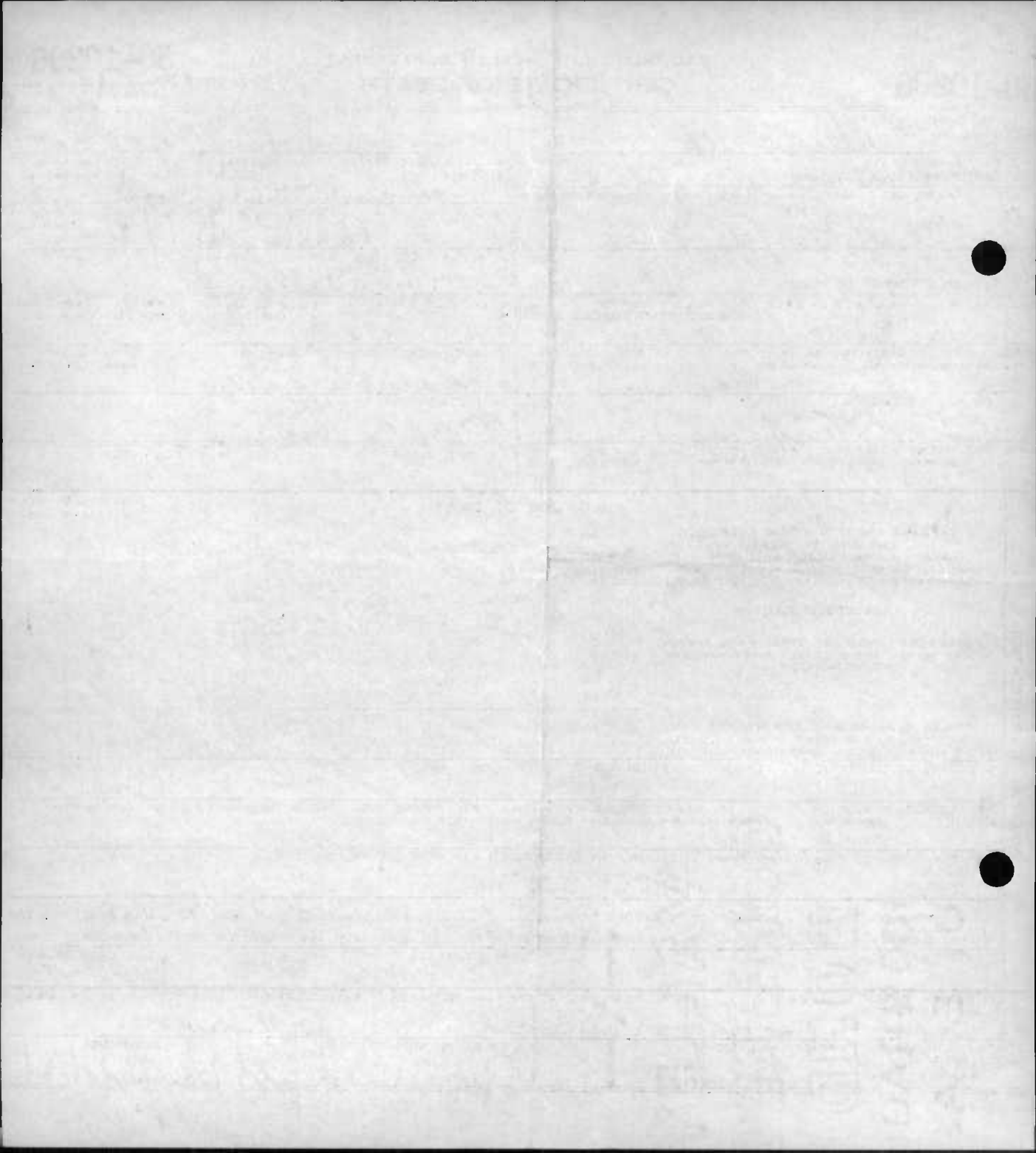
19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *Dec 1*, 1950, to *Nov- 28*, 1950, that I last saw the deceased alive on *Nov 28*, 1950, and that death occurred at *11:30 P* m., from the causes and on the date stated above.

23A. SIGNATURE <i>E. Gill Hall M.D.</i>	23B. ADDRESS <i>1631 E. North Ave</i>	23C. DATE SIGNED <i>Nov 29-1950</i>
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24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>Nov 30, 1950</i>	24C. NAME OF CEMETERY OR CREMATORY <i>Cathedral</i>	24D. LOCATION (City, town, or county) (State) <i>Baltimore</i>
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DATE RECEIVED BY LOCAL REGISTRAR <i>NOV 29 1950</i>	REGISTRAR'S SIGNATURE <i>William H. Williams</i>	25. FUNERAL DIRECTOR <i>Rita Wiedefeld</i>	ADDRESS <i>900 E. Biddle St</i>
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653
50-10207BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10207

Registered No.

BIRTH NO.		1. NAME OF DECEASED (Type or Print) ROBERT S. BRUNT		2. DATE OF DEATH Nov. 28, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Md. B. COUNTY 27-13			
B. FULL NAME OF HOSPITAL OR INSTITUTION 22 Merrymount Rd.		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore			
c. Length of stay in Baltimore		D. STREET ADDRESS (If rural, give location) 22 Merrymount Rd.			
5. SEX male	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH Apr. 1, 1862	9. AGE (In years, last birthday) 88	10. Under 1 Year Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Editor		10B. KIND OF BUSINESS OR INDUSTRY Newspaper		11. BIRTHPLACE (State or foreign country) New Jersey	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME Robert Brunt			
14. MOTHER'S MAIDEN NAME Mary Casey		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) -			
16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Mr. W. J. McClain 22 Merrymount Rd.			
18. 331X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) Cerebral vascular accident DUE TO (B) arterio sclerosis DUE TO (C) ... INTERVAL BETWEEN ONSET AND DEATH 5 days ?		19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION 0		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 4/16/50 , 19__, to 11/28/50 , 19__, that I last saw the deceased alive on 11/28/50 , 19__, and that death occurred at 8 P m., from the causes and on the date stated above.					
23A. SIGNATURE Francis W. Elmer		23B. ADDRESS M. D. 3406 St Paul St		23C. DATE SIGNED 11/29/50	
24A. BURIAL, CREMATION, REMOVAL (Specify) Removal		24B. DATE 11/29/50		24C. NAME OF CEMETERY OR CREMATORY Somerville	
24D. LOCATION (City, town, or county) (State) Somerville, N. J.		25. FUNERAL DIRECTOR ADDRESS Wm. J. Pickens & Sons - Balto. 832 Md.			
DATE RECEIVED BY LOCAL REGISTRAR NOV 29 1950		REGISTRAR'S SIGNATURE William J. Pickens		25. FUNERAL DIRECTOR ADDRESS Wm. J. Pickens & Sons - Balto. 832 Md.	

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CENTRAL BANK OF TEXAS

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530
50-10208BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50-10208
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

HARVEY HAMILTON BENNETT

2. DATE
OF
DEATH

Nov. 27, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION

2075 Rock Rose Ave.

Yrs.
Mos.
Days

C. Length of stay in Baltimore

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE

Md.

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore

D. STREET ADDRESS (If rural, give location)

2510 Guilford Ave.

5. SEX

male

6. COLOR OR RACE

white

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

single

8. DATE OF BIRTH

Aug. 19, 1882

9. AGE (in year-
last birthday)

68

If Under 1 Year

Months: Days: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

salesman (rtd)

10B. KIND OF BUSINESS OR INDUSTRY

Automobile

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Washington H. Bennett

14. MOTHER'S MAIDEN NAME

Amanda E. Dawson

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Kenneth A. Bourne - 327 Tunbridge Rd

18. 332X1

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Thrombosis
DUE TOINTERVAL BETWEEN
ONSET AND DEATH

2 wks

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) Cerebral Arteriosclerosis
DUE TO

10 yrs +

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e.g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10 Nov 1950, to 27 Nov 1950, that I last saw the deceased alive on 27 Nov 1950, and that death occurred at 8:55 m., from the causes and on the date stated above.

23. SIGNATURE

M.D.

M. D.

23B. ADDRESS

1261 E. Belvidere Ave

23C. DATE SIGNED

29 Nov 50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

11/30/50

24C. NAME OF CEMETERY OR CREMATORY

Quaker Burying Ground

24D. LOCATION (City, town, or county)

West River, Md.

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

NOV 29 1950

Wm. J. Pickens & Son - Balto Md.

20-11028

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**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

Registered No. **50-10209**

245
50-10209
BIRTH NO.

1. NAME OF DECEASED (Type or Print) MARY CATHERINE McLAIN		2. DATE OF DEATH 11-28-50	
3. PLACE OF DEATH: A. Baltimore City, Maryland Jenkins Memorial			
B. FULL NAME OF (If not in hospital or institution, give street address or location) Jenkins Memorial Hospital			
C. Length of stay in Baltimore 71 yrs.		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 9-08	
5. SEX M.		6. COLOR OR RACE W	
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) W		8. DATE OF BIRTH 2-15-79	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (State or foreign country) Balto., Md.	
10B. KIND OF BUSINESS OR INDUSTRY At Home		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Patrick Stanc		14. MOTHER'S MAIDEN NAME Margaret Ricci	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Mary Tilley		18. TOWN Towson, Md. 8412 Greenway Rd.	

CAUSE OF DEATH

18. 443X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	INTERVAL BETWEEN ONSET AND DEATH
(A) HYPERTENSIVE ARTERIOSCLEROTIC CARDIO-VASCULAR DISEASE DUE TO CONGESTIVE FAILURE (B) RT. HEMIPLEGIA DUE TO (C) HYPERTROPHIC ARTERITIS	

19A. DATE OF OPERATION 0	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **7/1**, 19**50** to **11/28**, 19**50** that I last saw the deceased alive on **11/27**, 19**50**, and that death occurred at **11:20 P.M.**, from the causes and on the date stated above.

23A. SIGNATURE John E. Shaw	23B. ADDRESS M.D. 2001 Avenue Park	23C. DATE SIGNED 11/28/50
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24A. BURIAL, CREMATION, REMOVAL (Specify) Burial	24B. DATE 12/1/50	24C. NAME OF CEMETERY OR CREMATORY New Cathedral Cem.	24D. LOCATION (city, town, or county) (State) Balto., Md.
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DATE RECEIVED BY LOCAL REGISTRAR NOV 29 1950	REGISTRAR'S SIGNATURE Thurston Williams, M.D.	25. FUNERAL DIRECTOR Wm. J. Scherer & Sons Balto Md.
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MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

1-1-19

DECEASED

DATE OF DEATH

AGE

PLACE OF BIRTH

SEX

EDUCATION

DATE OF BIRTH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

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DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

612

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50-10210

BIRTH NO. 50-10210

1. NAME OF DECEASED
(Type or Print)

John Randolph Groves, Jr.

2. DATE
OF
DEATH

Nov. 27, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION

Union Memorial Hospital

c. Length of stay in Baltimore

68 Yrs.
Mos.
Days

5. SEX

Male white

6. COLOR OR RACE

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Married

10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Owner (retd)

10B. KIND OF BUSINESS OR
INDUSTRY

Baking Powder Mfg

13. FATHER'S NAME

John R. Groves, Jr.

(Hannah Elizabeth Wilson)

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

no

17. INFORMANT

Mrs. Cora Groves

ADDRESS

207 Stoneleigh Rd
Baltimore, Md.

18. 420.0 I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A) DUE TO

Massive pulmonary embolism

INTERVAL BETWEEN
ONSET AND DEATH

10 minutes

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

peripheral venous thrombosis

weeks

(C) DUE TO

Chronic Congestive Cardiac failure

5 months

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

arteriosclerotic heart disease

1 year

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m.

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐22. I hereby certify that I attended the deceased from Sept. 7, 1950, to Nov. 27, 1950, that I last saw the
deceased alive on Nov. 27, 1950, and that death occurred at 1:59 P.M., from the causes and on the date stated above.

23A. SIGNATURE

Dr. F. Cox 32

23B. ADDRESS

M. O.

Union Memorial Hospital

23C. DATE SIGNED

11/27/50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)
Burial

24B. DATE

11/30/50

24C. NAME OF CEMETERY OR CREMATORY

Druid Ridge Cem.

24D. LOCATION (City, town, or county)

Pikesville, Md.

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Hamilton Williams

25. FUNERAL DIRECTOR

ADDRESS

Wm. J. Dickner & Sons - Balt

NOV 29 1950

VS 150

29047

937

Md.

MEDICAL CERTIFICATION

50-10810

50-10810

John F. Kennedy
President of the United States
Washington, D.C.
Dear Mr. Kennedy:
I am writing to you today to express my
sincere appreciation for the many
ways in which you and your administration
have worked to improve the lives of
all Americans. Your leadership and
commitment to the principles of
freedom and justice have been a source
of inspiration and guidance for
many of us. We are proud to have
you as our President, and we look
forward to continuing to work with
you to build a better future for
our country.

**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

50-10211
Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED (Type or Print) Daniel J McGrath		2. DATE OF DEATH November 27 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland Baltimore City		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY _____	
B. FULL NAME OF HOSPITAL OR INSTITUTION 1343 Gorsuch Ave		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore	
C. Length of stay in Baltimore 54 yrs		D. STREET ADDRESS (If rural, give location) 1343 Gorsuch Ave	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Nov 14 1879
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Telegraph Operator		10B. KIND OF BUSINESS OR INDUSTRY Railroad (Retired)	9. AGE (In years last birthday) 81
11. BIRTHPLACE (State or foreign country) Toledo Ohio		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Daniel McGrath		14. MOTHER'S MAIDEN NAME Mary Shanahan	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Agnes M McGrath (Wife)		ADDRESS 1343 Gorsuch Ave.	

18. 4221 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) (A) Arteriosclerotic Cardio-Vascular Disease DUE TO (B) Cerebral Hemorrhage DUE TO (C) _____ ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	INTERVAL BETWEEN ONSET AND DEATH 5 yrs 4 days
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19A. DATE OF OPERATION 0	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

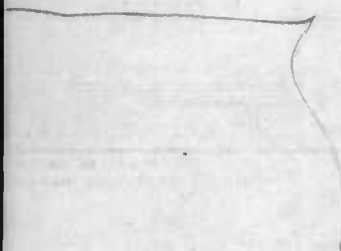
22. I hereby certify that I attended the deceased from 11-15-50, 1950, to 11-27, 1950, that I last saw the deceased alive on 11-27, 1950, and that death occurred at 4:30 p.m., from the causes and on the date stated above.

23A. SIGNATURE P.D. Flynn	23B. ADDRESS 11 E. Chase St	23C. DATE SIGNED 11/29/50
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24A. BURIAL, CREMATION, REMOVAL (Specify) Burial	24B. DATE Nov. 30, 1950	24C. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery	24D. LOCATION (City, town, or county) (State) Baltimore Md.
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DATE RECEIVED BY LOCAL REGISTRAR NOV 29 1950	REGISTRAR'S SIGNATURE Wm. J. Williams, M.D.	25. FUNERAL DIRECTOR J. Melville Jenkins	ADDRESS 2713 Kirk Ave
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RECEIVED
HISTORICAL SOCIETY
OF THE CITY OF NEW YORK



542

50-10212
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50-10212
Registered No.

1. NAME OF DECEASED (Type or Print) <i>Ludwika Danielewska</i>		2. DATE OF DEATH <i>November 28, 1950</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>md.</i> B. COUNTY <i>X</i>	
5. FULL NAME OF HOSPITAL OR INSTITUTION <i>JOHNS HOPKINS HOSPITAL</i>		6. CITY OR TOWN (If outside corporate limits, write FULL and give township) <i>Baltimore</i>	
7. STREET ADDRESS (If rural, give location) <i>283 Mason Court</i>		8. DATE OF BIRTH <i>Aug 4 1872</i>	
9. AGE (in years last birthday) <i>78</i>		10. AGE (in years last birthday) <i>78</i>	
11. BIRTHPLACE (State or foreign country) <i>Poland</i>		12. CITIZEN OF WHAT COUNTRY? <i>Poland</i>	
13. FATHER'S NAME <i>August Suchowski</i>		14. MOTHER'S MAIDEN NAME <i>?</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>	
17. INFORMANT <i>JOHNS HOPKINS HOSPITAL</i>		ADDRESS	

18. <i>330X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Subarachnoid hemorrhage</i>		INTERVAL BETWEEN ONSET AND DEATH
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <i>central Thrombosis & atherosclerosis</i>		
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION <i>0</i>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>11-28, 1950</i> , to <i>11-28, 1950</i> , that I last saw the deceased alive on <i>11-28, 1950</i> and that death occurred at <i>10:24 p.m.</i> , from the causes and on the date stated above.					
23A. SIGNATURE <i>Thomas J. Walsh M.D.</i>		23B. ADDRESS <i>JOHNS HOPKINS HOSPITAL</i>		23C. DATE SIGNED <i>11-28-50</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>Dec 2-50</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Holy Cross</i>	
24D. LOCATION (City, town, or county) (State) <i>German Hill Rd. Balt Co</i>		24E. FUNERAL DIRECTOR <i>Rippel Bros. 1800 E Lombard St</i>		24F. ADDRESS	

NOV 29 1950

VS 150

83a

91871-18

31571

12/1/51

W-18-00

1-351

616
50-10213

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50-10213

BIRTH NO.		1. NAME OF DECEASED (Type or Print) JOHN E. HARPER		2. DATE OF DEATH Nov. 27, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY			
B. FULL NAME OF HOSPITAL OR INSTITUTION Doctor's Hospital		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 12-03			
C. Length of stay in Baltimore LIFE		D. STREET ADDRESS (If rural, give location) 2504 Gilford AVE Guilford			
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH APRIL 17 19 11	9. AGE (In years last birthday) 39	10. Under 1 Year Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ACCOUNTANT		10B. KIND OF BUSINESS OR INDUSTRY SELF		11. BIRTHPLACE (State or foreign country) BALTIMORE MD.	
13. FATHER'S NAME BENJAMIN HARPER.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NO		16. SOCIAL SECURITY NO.		14. MOTHER'S MAIDEN NAME ANNIE B. HILBERG	
17. INFORMANT DOROTHY R. HARPER		ADDRESS 2504 GUILFORD AVE			

18. 581.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) Fatty infiltration of the liver DUE TO ANTECEDENT CAUSES (B) Chronic alcoholism DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	

22. I certify that I took charge of the remains described above, held an Inspection & Inq. thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE William V. Wood		23B. CHIEF MEDICAL EXAMINER..... <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER..... <input checked="" type="checkbox"/> M.D. MEDICAL INVESTIGATOR.....		23C. DATE SIGNED Nov. 27, 1950	
24A. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24B. DATE NOV 30 1950	24C. NAME OF CEMETERY OR CREMATORY MOUNT OLIVET CEM.	24D. LOCATION (City, town, or county) (State) 2930 FREDERICK AVE MD.		
DATE RECEIVED BY LOCAL REGISTRAR NOV 29 1950	REGISTRAR'S SIGNATURE William V. Wood	25. FUNERAL DIRECTOR Duffel Bros 1800 FLOTHBARD ST			

320
50-10214
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10214

Registered No. _____

1. NAME OF DECEASED (Type or Print) <i>Mary Betts</i>			2. DATE OF DEATH <i>November 18, 1950</i>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Howard</i>		
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>St. Agness Hospital</i>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>One Spot</i>		
C. Length of stay in Baltimore Yrs. Mos. Days			D. STREET ADDRESS (If rural, give location) <i>Washington Blvd. 6200</i>		
5. SEX <i>female</i>	6. COLOR OR RACE <i>colored</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>1</i>	8. DATE OF BIRTH		9. AGE (In years last birthday) <i>22</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY <i>1</i>	11. BIRTHPLACE (State or foreign country) <i>7</i>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <i>7</i>			14. MOTHER'S MAIDEN NAME <i>7</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.	17. INFORMANT <i>9</i> ADDRESS		

18. <i>E981X</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	CAUSE OF DEATH (A) <i>Complete Atelectasis of left lung with Empyema left pleural space</i> DUE TO (B) <i>Fracture of left Radius</i> DUE TO (C) <i>Shotgun Wound of left Arm Chest and Abdomen</i>	INTERVAL BETWEEN ONSET AND DEATH
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION <i>November 16, 1950</i>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) <i>home</i>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <i>One Spot, Washington Blvd.</i>	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <i>November 16, 1950 10:30 p.m.</i>		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <i>Firearms</i>	
22. I certify that I took charge of the remains described above, held an <i>Autopsy</i> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input checked="" type="checkbox"/> , undetermined <input type="checkbox"/> .					
23A. SIGNATURE <i>William V. Smith</i>		23B. CHIEF MEDICAL EXAMINER..... ASSISTANT MEDICAL EXAMINER..... M.D. MEDICAL INVESTIGATOR.....		23C. DATE SIGNED <i>11-18-50</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Shipped</i>		24B. DATE <i>11-29-50</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Jackson Tenn.</i>	
24D. LOCATION (City, town, or county) (State)		25. FUNERAL DIRECTOR <i>Dr. Halstead</i>		ADDRESS <i>166 Bell Ave</i>	
DATE RECEIVED BY LOCAL REGISTRAR <i>NOV 29 1950</i>		REGISTRAR'S SIGNATURE <i>William V. Smith</i>		ADDRESS	

**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

50-10215
Registered No.

1. NAME OF DECEASED (Type or Print) PHILIP			2. DATE OF DEATH November 27, 1950		
3. PLACE OF DEATH: a. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Maryland b. COUNTY Baltimore		
b. FULL NAME OF (If not in hospital or institution, give street address or location) Franklin Square Hospital			c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore (Catonsville)		
c. Length of stay in Baltimore			d. STREET ADDRESS (If rural, give location) 167 Winters Lane		
5. SEX Male	6. COLOR OR RACE Colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH Nov 10 - 1876	9. AGE (In years last birthday) 74	10. Under 1 Year Months: Days: 11. Under 24 Hours Hours: Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Grave Digger Cemetery			11. BIRTHPLACE (State or foreign country) Catonsville Md		
13. FATHER'S NAME John Raveling			14. MOTHER'S MAIDEN NAME E. Esie ?		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
17. INFORMANT Mrs. Grace Johnson			ADDRESS Box 498		

CAUSE OF DEATH

18. E 812.4 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(A) Compound comminuted fracture of left tibia and fibula DUE TO (B) Pyelonephritis with terminal uremia DUE TO (C)	INTERVAL BETWEEN ONSET AND DEATH
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) Street	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Balto. Co. - Catonsville 5300 Winters Ave., 200' S. of Main Ave.,			
21D. TIME (Month) (Day) (Year) (Hour) 10-24-50 7 P.m.	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21F. HOW DID INJURY OCCUR? Pedestrian struck by auto			
22. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input checked="" type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .					
23A. SIGNATURE <i>William V. ...</i>		23B. CHIEF MEDICAL EXAMINER..... M.D. ASSISTANT MEDICAL EXAMINER..... MEDICAL INVESTIGATOR.....		23C. DATE SIGNED 11-27-50	

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial	24B. DATE Dec 2/1950	24C. NAME OF CEMETERY OR CREMATORY Western Star	24D. LOCATION (City, town, or county) (State) Catonsville, Md
DATE RECEIVED BY LOCAL REGISTRAR NOV 29 1950		REGISTRAR'S SIGNATURE <i>...</i>	25. FUNERAL DIRECTOR Holland ADDRESS 170c ...

460
50-10216BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10216

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Addie Fowler

2. DATE
OF
DEATH

Nov. 28, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

OSL. 4

B. FULL NAME OF
HOSPITAL OR
INSTITUTION

JOHNS HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence
A. STATE B. COUNTY before admission)

MARYLAND

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

BALTIMORE

D. STREET ADDRESS (If rural, give location)

1201 DRUID HILL AVE.

C. Length of stay in Baltimore

60

Yes
Mos.
Days

5. SEX

FEMALE

6. COLOR OR RACE

COLORED

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

WIDOWED

8. DATE OF BIRTH

9-17-72

9. AGE (in years
last birthday)

78

10 Under 1 Year
Months Days11 Under 24 Hours
Hours Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR
INDUSTRY

Home

11. BIRTHPLACE (State or foreign country)

No. Carolina

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Carter

14. MOTHER'S MAIDEN NAME

Julia

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

JOHNS HOPKINS HOSPITAL

18.

331X I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A)

Cerebral Vascular accident

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

Arterio Sclerosis

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11-26 1950, to 11-28, 1950, that I last saw the
deceased alive on 11-28, 1950, and that death occurred at 355 a.m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

M. D.

JOHNS HOPKINS HOSPITAL

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

NOV 29 1950

Baltimore, Md.
William H. Williams, Jr.1631 D and Hill Ave.
Holland Funeral Home

VS 150

MEDICAL CERTIFICATION

Chief of Police
New York City

Very truly yours,
J. Edgar Hoover
Director

563

50-10217

BIRTH NO. 50-26150

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50-10217

1. NAME OF DECEASED
(Type or Print)

Baby Girl Van Nort

2. DATE
OF
DEATH

11/21/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland Baltimore, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR INSTITUTE

South Baltimore General Hospital

Yrs.
Mos.
Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Harley Park

D. STREET ADDRESS (If rural, give location)

c. Length of stay in Baltimore

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

11/19/50

9. AGE (In years
last birthday)If Under 1 Year
Months: Days

2

If Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore Maryland

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

Thelma Van Nort

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

18. 776X I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A)

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

INTERVAL BETWEEN
ONSET AND DEATHII
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11/19, 1950, to 11/21, 1950, that I last saw the
deceased alive on 11/21, 1950, and that death occurred at 7:45A. m., from the causes and on the date stated above.

23A. SIGNATURE

M. D.

23B. ADDRESS

1213 Light Street

23C. DATE SIGNED

11/22/50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

JOHN HOPKINS MEDICAL SCHOOL NOV 27 1950

DATE RECEIVED BY
LOCAL REGISTRAR

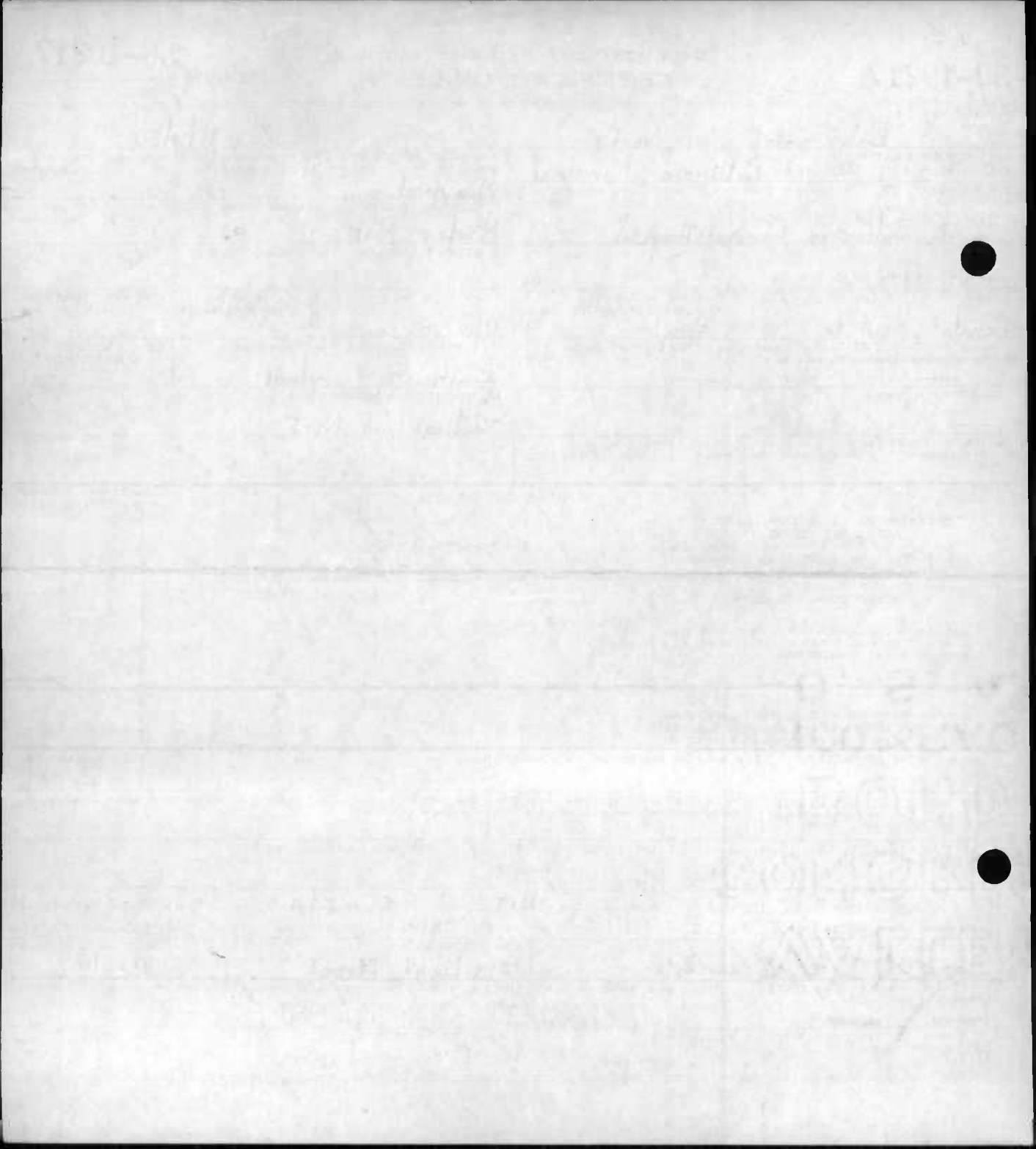
REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

NOV 29 1950

Commissioner of Health



213
50-10218
BIRTH NO.BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50-10218

1. NAME OF DECEASED (Type or Print) HERMAN NESBITT			2. DATE OF DEATH Nov. 12, 1950		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland U B. COUNTY		
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION MERCY HOSPITAL			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore K 4-01		
C. Length of stay in Baltimore			D. STREET ADDRESS (If rural, give location) 302 Forrest St. 0		
5. SEX male	6. COLOR OR RACE colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) U	8. DATE OF BIRTH U	9. AGE (In years last birthday) N 51	If Under 1 Year Months: Days If Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY K	11. BIRTHPLACE (State or foreign country) K		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME N O			14. MOTHER'S MAIDEN NAME O		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. N	17. INFORMANT N ADDRESS		

18. E916.0 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 1ST, 2nd, + 3rd Degree Burns DUE TO of body. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	INTERVAL BETWEEN ONSET AND DEATH
--	----------------------------------

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIB. <input type="checkbox"/> CAUSE OF DEATH.		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) Home		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 302 Forrest St. 3rd floor	
21D. TIME (Month) (Day) (Year) (Hour) 2:35 A.M. - Nov. 12, 1950		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? Conflagration - Mattress afire	
22. I certify that I took charge of the remains described above, held an Inspection & Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry , find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input checked="" type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .					
23A. SIGNATURE Stanley H. Dineacher M.D.		23B. CHIEF MEDICAL EXAMINER..... ASSISTANT MEDICAL EXAMINER..... MEDICAL INVESTIGATOR.....		23C. DATE SIGNED Nov. 12, 1950	
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE Nov 29 1950		24C. NAME OF CEMETERY OR CREMATORY UNIVERSITY MEDICAL SCHOOL NOV 29 1950	
24D. LOCATION (City, town, or county)		25. FUNERAL DIRECTOR Commissioner of Health		ADDRESS	

612
50-10219

State Anatomical

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10219
Registered No.

1. NAME OF DECEASED (Type or Print) ISAAC GROVES		2. DATE OF DEATH NOV 24, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland HAL 5		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY Montgomery	
5. FULL NAME OF HOSPITAL OR INSTITUTION JOHNS HOPKINS HOSPITAL		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) SILVER SPRING	
c. Length of stay in Baltimore Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) VIERS MILL RD. 6500	
5. SEX MALE	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) SINGLE	8. DATE OF BIRTH 8-18-87
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		9. AGE (in years last birthday) 63	
10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME Stanford Groves		14. MOTHER'S MAIDEN NAME Lucy T. Larp	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT JOHNS HOPKINS HOSPITAL		ADDRESS	

18. 540.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Pulmonary embolus		CAUSE OF DEATH (A) Pulmonary embolus DUE TO (B) Postoperative gastrostomy - cholecystectomy DUE TO (C) Tuberculosis of stomach + gall bladder		INTERVAL BETWEEN ONSET AND DEATH 4 hrs.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONOITION CAUSING IT. Amputation for gangrene					
19A. DATE OF OPERATION 11/11/50		19B. MAJOR FINDINGS OF OPERATION Tuberculosis of gastric ulcer + gall bladder		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 10-30 19 50 , to 11-24 , 19 50 , that I last saw the deceased alive on 11-24 , 19 50 , and that death occurred at 6:50 p m., from the causes and on the date stated above.					
23A. SIGNATURE Arthur K. Nelson M. D.		23B. ADDRESS JOHNS HOPKINS HOSPITAL		23C. DATE SIGNED 11/25/50	
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY UNIVERSITY MEDICAL SCHOOL NOV 27 1950	
24D. LOCATION (City, town, or county) (State)		25. FUNERAL DIRECTOR Commissioner of Health		ADDRESS	

11-1931

11-1931

11-1931

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320

50-10220

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10220

Registered No.

BIRTH NO. 50-25243

1. NAME OF DECEASED
(Type or Print)

Baby Boy BETZ

2. DATE
OF
DEATH

11-23-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland Baltimore, Md.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

B. COUNTY

before admission)

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR INSTITUTE

Franklin Square Hospital

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

2004 Hillside Drive

c. Length of stay in Baltimore

3

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

11-20-50

9. AGE (In years

last birthday)

11 Under 1 Year

Months: Days

11 Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

William Betz Jr.

14. MOTHER'S MAIDEN NAME

June Greeley

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

18. 761.5

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A)

Pneumonia

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

Prematurity

DUE TO

(C)

Caesarian Section - because

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

of Placenta Praevia.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m.

WHILE AT WORK ☐NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from Nov. 20, 1950, to Nov. 23, 1950, that I last saw the deceased alive on Nov. 23, 1950, and that death occurred at 3:20 p.m., from the causes and on the date stated above.

23A. SIGNATURE

Benjamin Amster

23B. ADDRESS

M. D.

Franklin Sq. Hospital

23C. DATE SIGNED

11/25/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

NOV 29 1950

Commissioner of Health

Commissioner of Health

VS 150

1590

MEDICAL CERTIFICATION

10-10-50

CERTIFICATE OF DEATH

IN THE CITY OF NEW YORK

DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE AT DEATH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY

PLACE OF ENTRY

DATE OF DEPARTURE

PLACE OF DEPARTURE

DATE OF RETURN

PLACE OF RETURN

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

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PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

ES-143089

50-10221

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10221

Registered No.

1. NAME OF DECEASED (Type or Print) Samuel Kennedy		2. DATE OF DEATH 11-12-50	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION Baltimore City Hospitals		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore	
c. Length of stay in Baltimore Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) 901 Fell Street	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH ?
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country) ?	
10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME ?		14. MOTHER'S MAIDEN NAME ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Records* Balto. City Hospitals Eastern Ave		ADDRESS 4940	

18. 332X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(A) Aspiration Pneumonia		DUE TO		10 days	
(B) Cerebral Thrombosis		DUE TO		2 weeks	
(C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					

19A. DATE OF OPERATION 0		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 11-3 , 19 50 , to 11-12 , 19 50 , that I last saw the deceased alive on 11-12 , 19 50 , and that death occurred at 3:30 A. from the causes and on the date stated above.					
23A. SIGNATURE P. S. Cohen M. D.		23B. ADDRESS 4940 Eastern Avenue		23C. DATE SIGNED 11-20-50	
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY UNIVERSITY MEDICAL SCHOOL NOV 28 1950	
24D. DATE RECEIVED BY LOCAL REGISTRAR NOV 29 1950		REGISTRAR'S SIGNATURE William H. Williams, M.D.		25. FUNERAL DIRECTOR Commissioner of Health ADDRESS	

1. NAME OF DECEASED (Type or Print) LOUIS RICHARDSON			2. DATE OF DEATH November 15, 1950		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 26-12		
B. FULL NAME OF (If not in hospital or institution, give street address or location) University Hospital			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore		
C. Length of stay in Baltimore Yrs. Mos. Days			D. STREET ADDRESS (If rural, give location) Baltimore City Hospital Infirmary		
5. SEX male	6. COLOR OR RACE colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) U	8. DATE OF BIRTH U	9. AGE (In years last birthday) 50	10. Under 1 Year Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY K	11. BIRTHPLACE (State or foreign country) K		12. CITIZEN OF WHAT COUNTRY? K
13. FATHER'S NAME O		14. MOTHER'S MAIDEN NAME O			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) W		16. SOCIAL SECURITY NO. N			
17. INFORMANT N		ADDRESS			

18. 443X	DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH	INTERVAL BETWEEN ONSET AND DEATH
	(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) Hypertensive cardiovascular disease	
	DUE TO			
	DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B)	
DUE TO		(C)		
<p>II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</p>				

MEDICAL C	19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
	21A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
	21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED m. WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	

22. I certify that I took charge of the remains described above, held an Inquiry & Inspection thereon and from Autopsy, Inspection or Inquiry the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23a. SIGNATURE <i>Stanley K. Overacher</i>		23b. CHIEF MEDICAL EXAMINER..... <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER..... <input checked="" type="checkbox"/> MEDICAL INVESTIGATOR		23c. DATE SIGNED Nov. 16, 1950
24a. BURIAL, CREMATION, REMOVAL (Specify): Burial	24b. DATE 12-1-50	24c. NAME OF CEMETERY OR CREMATORY UNIVERSITY MEDICAL CENTER	24d. LOCATION (City, town, or county) Annapolis, Md.	(State) Md.
DATE RECEIVED BY LOCAL REGISTRAR NOV 29 1950	REGISTRAR'S SIGNATURE <i>William J. Williams, Jr.</i>	25. FUNERAL DIRECTOR <i>Joseph L. Russ</i> Commissioner of Health		ADDRESS 1200 McCulloch St.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		DATE OF DEATH		PLACE OF BIRTH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		SIGNATURE OF REGISTRAR		SIGNATURE OF PHYSICIAN		SIGNATURE OF FUNERAL HOME		SIGNATURE OF WITNESSES			

230

EAST

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10223

Registered No.

50-10223

BIRTH NO.

50-26057

1. NAME OF DECEASED
(Type or Print)

Joseph Wielepski East

2. DATE
OF
DEATH

11/27/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution; residence

A. STATE

B. COUNTY

before admission)

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION

619 N. Ellwood Ave

C. CITY OR TOWN

Maryland

Baltimore

D. STREET ADDRESS (If rural, give location)

619 N. Ellwood Ave.

C. Length of stay in Baltimore

2 hr

5. SEX

Male

6. COLOR OR RACE

white

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

11/27/50

9. AGE (In years,
last birthday)If Under 1 Year
Months Days
If Under 24 Hours
Hours Min.

2

10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

none

10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

John East

14. MOTHER'S MAIDEN NAME

Deloris Mary Wielepski

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

mother

619 N. Ellwood Ave.

18. 776X I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A)

Prematurity

(24 weeks)

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

Unknown

DUE TO

(C)

No prenatal care

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e.g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT

NOT WHILE

m.

WORK

AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7:22 PM 11/17/50, to 9:30 PM 11/19/50, that I last saw the deceased alive on 11/27/1950, and that death occurred at 9:30 P. M., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

M. D.

11 E. Chase St

11/28/50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

JOHN HOPKINS MEDICAL SCHOOL NOV 28 1950

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR OF HEALTH

ADDRESS

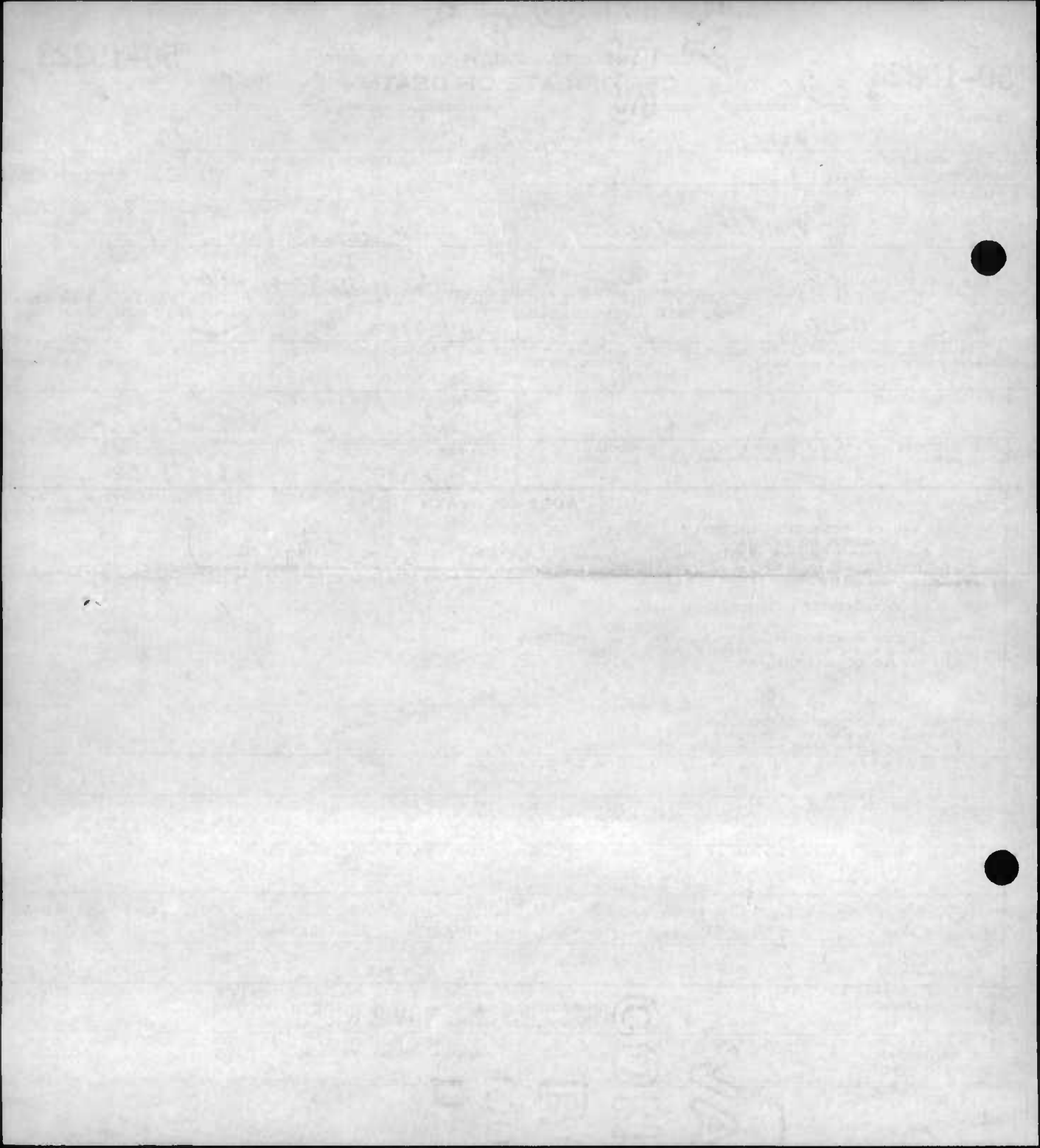
NOV 29 1950

William A. Williams, Jr.

VS 150

159.0

MEDICAL CERTIFICATION



H 520
50-10224

CERTIFICATE CORRECTED 12-1-50
BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10224
Registered No.

1. NAME OF DECEASED (Type or Print) CATHERINE A. HANKS		2. DATE OF DEATH November 27, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland Balto. City		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION Provident Hospital		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 16-04	
C. Length of stay in Baltimore 10 Yrs.		D. STREET ADDRESS (If rural, give location) 2022 W. Lanvale Street	
5. SEX Female	6. COLOR OR RACE Colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 10/28/1909
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY At Home	9. AGE (in years last birthday) 41
11. BIRTHPLACE (State or foreign country) Onancock Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James White		14. MOTHER'S MAIDEN NAME Ellen ?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT George H. Hanks		ADDRESS 2022 W. Lanvale St	

18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Hypertensive cardiovascular renal disease (A) DUE TO		INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO		
(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .				
23A. SIGNATURE William V. Lowrey		23B. CHIEF MEDICAL EXAMINER..... M.D. ASSISTANT MEDICAL EXAMINER..... MEDICAL INVESTIGATOR.....	23C. DATE SIGNED 11-29-50	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial	24B. DATE 11/30/1950	24C. NAME OF CEMETERY OR CREMATORY Onancock	24D. LOCATION (City, town, or county) (State) Onancock Accomac Co. Va.	
DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR Elroy D. Wilson, 1000 Bampton		

V S 1251 291950

1312

13560
50-10225BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10225

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

JEROME

BONNAR

2. DATE
OF
DEATH

November 27, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland Balto. City

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION

Baltimore City Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

Maryland

B. COUNTY

before admission)

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1514 Swallow Avenue

c. Length of stay in Baltimore

Life

Yrs.
Mos.
Days

5. SEX

Male

6. COLOR OR RACE

Colored

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

June 1, 1949

9. AGE (In years
last birthday)

I

H Under 1 Year
Months: Days

4

H Under 24 Hours
Hours: Min.

27

10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

None

10B. KIND OF BUSINESS OR
INDUSTRY

None

11. BIRTHPLACE (State or foreign country)

Baltimore Md.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Willie

Bonner

14. MOTHER'S MAIDEN NAME

Louise

Smith

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Violet Butler 228 Douglas Court

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) Interstitial pneumonia

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE
WORK AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy thereon and from
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day, stated above,
and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

23B. CHIEF MEDICAL EXAMINER ☐

23C. DATE SIGNED

M.D.

ASSISTANT MEDICAL EXAMINER ☒

11-27-50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

11/30/1950

24C. NAME OF CEMETERY OR CREMATORY

Mt. Calvary Cem.

24D. LOCATION (City, town, or county)

Brooklyn Md.

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

Elmer O. Wilson 1000 Quaintance

V 1051 291950

114E

25-1083

RECEIVED

25-1083



**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

50-10226

Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED (Type or Print) HENRY COLBY ILER			2. DATE OF DEATH Nov. 29, 1950		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Va. B. COUNTY V-43		
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) US Marine Hospital Wyman Pk. Drive & 31st St.			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Arlington		
C. Length of stay in Baltimore 57 days			D. STREET ADDRESS (If rural, give location) Apt. 247- Colonial Village		
5. SEX M	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 4/24/05	9. AGE (In years last birthday) 45	If Under 1 Year: Months: Days: If Under 24 Hours: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY Civil Service	11. BIRTHPLACE (State or foreign country) Ky.		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME William Iler			14. MOTHER'S MAIDEN NAME Nellie Young		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) ?		16. SOCIAL SECURITY NO. ?	17. INFORMANT ADDRESS Records- US Marine Hospital, Balto, Md.		

18. 162X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Carcinoma of Right lung with metastasis to vertebrae, liver; and adrenals.		INTERVAL BETWEEN ONSET AND DEATH unknown
DUE TO (A) _____		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (B) _____		
(C) _____		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION 2		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Oct. 3, 1950 , to Nov. 29, 1950 , that I last saw the deceased alive on Nov. 29, 1950 , and that death occurred at 2:55 P.m. , from the causes and on the date stated above.					
23A. SIGNATURE L. Ray Howard		23B. ADDRESS US Marine Hospital, Balto, Md.		23C. DATE SIGNED	
24A. BURIAL, CREMATION, REMOVAL (Specify) Removal	24B. DATE 11-29-50	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State) Washington D.C.		
DATE RECEIVED BY LOCAL REGISTRAR NOV 30 1950	REGISTRAR'S SIGNATURE William H. Williams, Jr.	25. FUNERAL DIRECTOR S. H. Davis Co. Wash. D.C.		ADDRESS	

MEDICAL CERTIFICATION

10558

CERTIFICATE OF DEATH

STATE OF NEW YORK

10558

10558

10558

35
-10227

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10227

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

PANSY ROSS ANNADOWN

2. DATE
OF
DEATH

Nov. 27, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR US Marine Hospital

INSTITUTION Wyman Pk. Drive & 31st St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Florida B. COUNTY V-08

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Tarpon Springs

D. STREET ADDRESS (If rural, give location)

c. Length of stay in Baltimore

209 days

Yrs.
Mos.
Days

5. SEX

F

6. COLOR OR RACE

W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

6/22/02

9. AGE (In years last birthday)

48

10 Under 1 Year

Months

Days

11 Under 24 Hours

Hours

Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Cook

10B. KIND OF BUSINESS OR INDUSTRY

Seafarer

11. BIRTHPLACE (State or foreign country)

England

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

John Ross Turin

14. MOTHER'S MAIDEN NAME

Alice Stone

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

?

16. SOCIAL SECURITY NO.

?

17. INFORMANT

ADDRESS

Records- US Marine Hospital, Balto, Md.

18.

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

Carcinoma right breast with metastases to pleura

INTERVAL BETWEEN ONSET AND DEATH

Unknown

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
1945

19B. MAJOR FINDINGS OF OPERATION
Carcinoma of breast (right)

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May 2, 1950, to Nov. 27, 1950, that I last saw the deceased alive on Nov. 27, 1950, and that death occurred at 9:17 A.M., from the causes and on the date stated above.

23A. SIGNATURE

Jacob Colsky, MD

23B. ADDRESS

US Marine Hospital, Balto, Md.

23C. DATE SIGNED

11/29/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

11/29/50

24C. NAME OF CEMETERY OR CREMATORY

Vinson Funeral Home

24D. LOCATION (City, town, or county)

Tarpon Springs Florida

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

William H. Williams, Jr.

25. FUNERAL DIRECTOR

ADDRESS

Carl H. McClinton, Jr.

VS 150

75455

403-E-25-4-H

050.0

MEDICAL CERTIFICATION

140
-10228

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10228

Registered No. _____

1. NAME OF DECEASED (Type or Print) LOUIS APPLE			2. DATE OF DEATH 11/29/1950		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) A. STATE MARYLAND B. COUNTY 1504		
B. FULL NAME OF HOSPITAL OR INSTITUTION 1828 WULBROOK AVE			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTO		
C. Length of stay in Baltimore 63			D. STREET ADDRESS (If rural, give location) 1828 WULBROOK AVE		
5. SEX MALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH		
			9. AGE (in years last birthday) 87		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TRAVELING SALESMAN			10B. KIND OF BUSINESS OR INDUSTRY		
13. FATHER'S NAME NOT KNOWN			11. BIRTHPLACE (State or foreign country) Russia		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No			12. CITIZEN OF WHAT COUNTRY? U.S.G.		
16. SOCIAL SECURITY NO.			14. MOTHER'S MAIDEN NAME NOT KNOWN		
17. INFORMANT			ADDRESS OSCAR APPLE - 3502 REIST. RD		

18. 443X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Hypertensive Cardis - vascular Disease		INTERVAL BETWEEN ONSET AND DEATH 2
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (A) _____ DUE TO _____ (B) _____ DUE TO _____ (C) _____		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION 0		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED M. WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from request , 19 49 to Nov 29 , 19 50 , that I last saw the deceased alive on Nov 29 , 19 50 and that death occurred at 11:15 A.M. , from the causes and on the date stated above.					
23A. SIGNATURE Louis T. Larry		23B. ADDRESS 1844 W. North Ave		23C. DATE SIGNED 11/29/50	
24A. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 11/30/1950		24C. NAME OF CEMETERY OR CREMATORY Windson Hill Rd	
24D. LOCATION (City, town, or county) BALTO		24E. STATE MD		25. FUNERAL DIRECTOR HACK LEWIS INC - 2400 Eutan Pl	
DATE RECEIVED BY LOCAL REGISTRAR NOV 30 1950		REGISTRAR'S SIGNATURE William M. Williams		ADDRESS	

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55
50-10229
BIRTH NO. 50-24570

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10229
Registered No.

1. NAME OF DECEASED (Type or Print) FRANCES HICKMAN			2. DATE OF DEATH November 21, 1950		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore		
B. FULL NAME OF (If not in hospital or institution, give street address or location) University Hospital			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore		
C. Length of stay in Baltimore Yrs. 0 Mos. 0 Days 0			D. STREET ADDRESS (If rural, give location) 923 Shields Place		
5. SEX female	6. COLOR OR RACE colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) U	8. DATE OF BIRTH 11-16-50	9. AGE (In years last birthday) 5	10. MONTHS 5
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country) K		
10B. KIND OF BUSINESS OR INDUSTRY K			12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME Geo. Hickman			14. MOTHER'S MAIDEN NAME Miss Beurel		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) B			16. SOCIAL SECURITY NO. N		
17. INFORMANT N			ADDRESS		

18. 756 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) Congenital obstruction of jejunum DUE TO	CAUSE OF DEATH	INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO		
(C) DUE TO		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE R S Fisher	23B. CHIEF MEDICAL EXAMINER..... <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER..... <input type="checkbox"/>	23C. DATE SIGNED Nov. 21, 1950
24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE 11-27-50	24C. NAME OF CEMETERY OR CREMATORY Balts. City Morgue
24D. LOCATION (City, town, or county)	25. FUNERAL DIRECTOR W. H. Williams, Jr.	ADDRESS
DATE RECEIVED BY LOCAL REGISTRAR NOV 30 1950	REGISTRAR'S SIGNATURE	

543

50-10230

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10230

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) JERRY ANEWALT			2. DATE OF DEATH Nov. 29, 1950		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Pa. B. COUNTY V-25		
B. FULL NAME OF (If not in hospital or institution, give street address or location) US Marine Hospital C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) East Stroudsburg			D. STREET ADDRESS (If rural, give location) 18 Day Street		
c. Length of stay in Baltimore 3 days Yrs. 3 Mos. 0 Days 0					
5. SEX M	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH 2/19/41		9. AGE (In years last birthday) 9
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Pa.		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME John Anewalt			14. MOTHER'S MAIDEN NAME Marion Young		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. None	17. INFORMANT ADDRESS Records- US Marine Hospital, Balto, Md.		

18. 204.3 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Acute leukemia with multiple hemorrhages (A) DUE TO	CAUSE OF DEATH Acute leukemia with multiple hemorrhages	INTERVAL BETWEEN ONSET AND DEATH Unknown
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	(B) DUE TO	
	(C)	

19A. DATE OF OPERATION 2	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from Nov. 26, 1950 , to Nov. 29, 1950 , that I last saw the deceased alive on Nov. 29, 1950 , and that death occurred at 1:35 P.m. , from the causes and on the date stated above.		
23A. SIGNATURE John L. Wilson, Medical Director	23B. ADDRESS US Marine Hospital, Balto, Md.	23C. DATE SIGNED 11/29/50

24A. BURIAL, CREMATION, REMOVAL Removal	24B. DATE 11/30/50	24C. NAME OF CEMETERY OR CREMATORY Brodheads ville, Pa.	24D. LOCATION (City, town, or county) (State) Pa.
DATE RECEIVED BY LOCAL REGISTRAR NOV 30 1950	REGISTRAR'S SIGNATURE John L. Wilson	25. FUNERAL DIRECTOR Ellsworth Umacost - Georgetown	ADDRESS 5118

THE

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Date: 2.1.2018

718

400
50-10231BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50-10231

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

JAMES EDWARD HALL

2. DATE
OF
DEATH

Nov. 28, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION

St. Agnes Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution: residence
A. STATE B. COUNTY before admission)

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township)
Baltimore

D. STREET ADDRESS (If rural, give location)

1946 Penrose Ave.

c. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)
married

8. DATE OF BIRTH

Feb. 25, 1894

9. AGE (In years
last birthday)

36

If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)
Cook10B. KIND OF BUSINESS OR
INDUSTRY
Lumber Co. of Balto.

11. BIRTHPLACE (State or foreign country)

Norfolk, Virginia

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

William A. Hall

(R + W)

14. MOTHER'S MAIDEN NAME

Mollie Coppersmith

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.
216-18-0913

17. INFORMANT

ADDRESS

Wm. R. Hall, 1946 Penrose Avenue

18. E 819.4, and 161X

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) Crushed chest

DUE TO

ANTECEDENT CAUSES

Subcutaneous emphysema

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

DUE TO

(C)

INTERVAL BETWEEN
ONSET AND DEATHII
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

Carcinoma of the larynx

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. EXTERNAL CAUSE WAS
UNDERLYING ☒ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)

Street

21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

Anne Arundel Co.
At Hillcrest near Dorsey Maryland 5200

21D. TIME (Month) (Day) (Year) (Hour)

F. INJURY

NOV. 22, 1950

6

m.

21E. INJURY OCCURRED

WHILE AT

WORK ☐

NOT WHILE

AT WORK ☒

21F. HOW DID INJURY OCCUR?

Auto into culvert

22. I certify that I took charge of the remains described above, held an Inspection & Inq. thereon and from
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,
and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

William V. Smith

23B. CHIEF MEDICAL EXAMINER.....☐ASSISTANT MEDICAL EXAMINER.....☒MEDICAL INVESTIGATOR.....☐

23C. DATE SIGNED

Nov. 28, 1950

M.D.

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

burial

24B. DATE

11/30/50

24C. NAME OF CEMETERY OR CREMATORY

St. Peters

24D. LOCATION (City, town, or county)

Baltimore, Maryland

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

William V. Smith

25. FUNERAL DIRECTOR

ADDRESS

Wm. Cook, Inc 1217 St. Paul Street

NOV 30 1950

VS 151

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MEDICAL CERTIFICATION

UNITED STATES DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
STATE OF NEW YORK

1931-10-1

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**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

Registered No. **50-10232**

400
50-10232

1. NAME OF DECEASED (Type or Print) JAMES EDWARD HALL			2. DATE OF DEATH Nov. 28, 1950		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 21-01		
B. FULL NAME OF (If not in hospital or institution, give street address or location) University Hospital			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore		
c. Length of stay in Baltimore			D. STREET ADDRESS (If rural, give location) 1003 Ridgely St.		
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH Aug. 14, 1879		9. AGE (In years last birthday) 71 If Under 1 Year Months: Days: If Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Handy-man		10B. KIND OF BUSINESS OR INDUSTRY unemployed	11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Walter Hall			14. MOTHER'S MAIDEN NAME		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or (unknown)) no		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS Minnie A. Hall, 705 W. Cross Street		

18. 002X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Far advanced pulmonary tuberculosis (A) DUE TO		INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES (B) DUE TO		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (C) DUE TO		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	

22. I certify that I took charge of the remains described above, held an Inspection & Inq. thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐.

23A. SIGNATURE <i>William A. Smith</i>		23B. CHIEF MEDICAL EXAMINER..... <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER..... <input checked="" type="checkbox"/> M.D. MEDICAL INVESTIGATOR..... <input type="checkbox"/>		23C. DATE SIGNED Nov. 28, 1950	
24A. BURIAL, CREMATION, REMOVAL (Specify) burial		24B. DATE 11/30/50		24C. NAME OF CEMETERY OR CREMATORY St. Peters	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland					

DATE RECEIVED BY LOCAL REGISTRAR NOV 30 1950		REGISTRAR'S SIGNATURE <i>William A. Smith</i>		25. FUNERAL DIRECTOR ADDRESS Wm. Cook, Inc. 1217 St. Paul Street	
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MEDICAL CERTIFICATION

200
0-10233BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50-10233
Registered No.

1. NAME OF DECEASED (Type or Print) EDWIN L. FOOS		2. DATE OF DEATH NOVEMBER 28, 1950	
3. PLACE OF DEATH: a. Baltimore City, Maryland Baltimore Md.		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 29-03	
b. FULL NAME OF HOSPITAL OR INSTITUTION South Baltimore General Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore	
c. Length of stay in Baltimore Life		d. STREET ADDRESS (If rural, give location) 1530 S. Charles Street	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 6/11/1895
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Brakeman		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
10b. KIND OF BUSINESS OR INDUSTRY Western Md. R.R.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME John W. Foos		14. MOTHER'S MAIDEN NAME Sadie Kieffer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) yes		16. SOCIAL SECURITY NO. 705-10-5346	
17. INFORMANT Helen M. Foos		ADDRESS 1530 S. Charles St	
18. 443 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) My extensive cardiovascular disease		INTERVAL BETWEEN ONSET AND DEATH 3 years	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. congestive Heart failure		DUE TO Empyema, lungs, right	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21d. TIME (Month) (Day) (Year) (Hour) INJURY	
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from September 19, 1950 to November 28, 1950 , that I last saw the deceased alive on Nov. 28, 1950 , and that death occurred at 10:25 p.m. , from the causes and on the date stated above.			
23a. SIGNATURE Martin C. Macapangan		23b. ADDRESS So. Balto. Gen. Hosp.	
23c. DATE SIGNED Nov. 28/1950			
24a. BURIAL, CREMATION, REMOVAL (Specify) Buried		24b. DATE Dec 1, 1950	
24c. NAME OF CEMETERY OR CREMATORY Western		24d. LOCATION (City, town, or county) (State) Balto Md	
DATE RECEIVED BY LOCAL REGISTRAR NOV 30 1950		REGISTRAR'S SIGNATURE W. Williams	
25. FUNERAL DIRECTOR A. Howard Brown		ADDRESS 1400 S. Charles St	

250

REA-143656

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10234

Registered No.

50-10234

BIRTH NO. 50-25374

1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH	
Baby Girl Wickham-DeSylvia		Nov. 24, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTE Baltimore City Hospitals 4940 Eastern Avenue		A. STATE Maryland B. COUNTY Baltimore	
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore		D. STREET ADDRESS (If rural, give location) 635 Melvins Drive 5300	
c. Length of stay in Baltimore Life		8. DATE OF BIRTH	
5. SEX Female		9. AGE (In years last birthday)	
6. COLOR OR RACE Negro		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single		11. BIRTHPLACE (State or foreign country)	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		12. CITIZEN OF WHAT COUNTRY?	
10B. KIND OF BUSINESS OR INDUSTRY		13. FATHER'S NAME	
John Wickham		14. MOTHER'S MAIDEN NAME	
De Sylvia Chase		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	
16. SOCIAL SECURITY NO.		17. INFORMANT	
Records: B. C. H. 4940 Eastern Avenue		ADDRESS	

CAUSE OF DEATH

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, apoplexy, etc. It means the disease, injury or complication which caused death.)	(A) Prematurity, Immaturity	INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES	(B) Fetal Atelectasis	Life
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(C)	Life
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE <input type="checkbox"/> AT WORK	21F. HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from 11-24, 1950, to 11-24, 1950, that I last saw the deceased alive on 11-24, 1950, and that death occurred at 8:30P m., from the causes and on the date stated above.		
23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
M. D.	4940 Eastern Avenue	

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Cremation	11-27-50	B. C. H. Crematory	Baltimore, Maryland
DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
NOV 30 1950			

1590

MEDICAL CERTIFICATION

100-1000

UNITED STATES DEPARTMENT OF JUSTICE

CENTRAL BUREAU OF INVESTIGATION

100-1000

100-1000



520

50-10235

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10235

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Babyboy Domico

2. DATE
OF
DEATH

NOV 27 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

JOHNS HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

2513 Welch Ave. 5200

c. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

Male

6. COLOR OR RACE

white

7. SINGLE. MARRIED.
WIDOWED. DIVORCED (Specify)

S.

8. DATE OF BIRTH

10-31-50

9. AGE (in years last birthday)

If Under 1 Year Months: Days
If Under 24 Hours Hours: Min.

28

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Edward Domico

14. MOTHER'S MAIDEN NAME

Louise

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS

JOHNS HOPKINS HOSPITAL

18.

776 X I

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A)

Prematurity

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from 10-31-1950 to 11-27-1950 that I last saw the deceased alive on 11-27-1950 and that death occurred at m., from the causes and on the date stated above.

23A. SIGNATURE

Leonard F. Rosenzweig M. O.

23B. ADDRESS

JOHNS HOPKINS HOSPITAL

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

VS 150

Hospital Asper

159.0

MEDICAL CERTIFICATION

552

0-10236(438145)

BIRTH NO. 30-24947

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50-10236

1. NAME OF DECEASED (Type or Print)		Baby Girl Pennington "Iola"		2. DATE OF DEATH November 19, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY			
B. FULL NAME OF HOSPITAL OR INSTITUTION The Johns Hopkins Hospital		C. CITY OR TOWN (If outside corporate limits, write FULL and give township) Baltimore			
D. STREET ADDRESS (If rural, give location) 1427 S. Hanover Street		E. LENGTH OF STAY IN BALTIMORE Yrs. Mos. Days			
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) single	8. DATE OF BIRTH November 18, 1950	9. AGE (In years last birthday) 1	10. Under 1 Year Months: Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10B. KIND OF BUSINESS OR INDUSTRY -	11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Charles Amos Pennington		14. MOTHER'S MAIDEN NAME Iola Mary Stein			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Hospital Records	

18. 761.5 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	CAUSE OF DEATH Atelectasis & pneumonia (A) DUE TO Intracranial infection (B) DUE TO Premature rupture of membranes in mother (C) Prematurity	INTERVAL BETWEEN ONSET AND DEATH 15 hrs before birth before birth
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19A. DATE OF OPERATION 2	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from November 18, 1950, to November 19, 1950, that I last saw the deceased alive on Nov. 19, 1950, and that death occurred at 2:00 P.m., from the causes and on the date stated above.

23A. SIGNATURE B. J. J. J.	23B. ADDRESS M. D. 601 N. Broadway	23C. DATE SIGNED Nov. 21, 1950
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24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY Forest Burial	24D. LOCATION (City, town, or county) (State)
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DATE RECEIVED BY NOV 30 1950	REGISTRAR'S SIGNATURE Huntington Williams, M.D.	25. FUNERAL DIRECTOR 0 2 3 5	ADDRESS
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50-10338

CERTIFICATE OF DEATH

STATE OF NEW YORK

DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BURIAL

PLACE OF BURIAL

NAME OF FUNERAL HOME

NAME OF MINISTER

NAME OF CHURCH

NAME OF CEMETERY

NAME OF CLERGYMAN

NAME OF MINISTER

NAME OF CHURCH

NAME OF CEMETERY

NAME OF CLERGYMAN

NAME OF MINISTER

NAME OF CHURCH

NAME OF CEMETERY

NAME OF CLERGYMAN

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NAME OF CEMETERY

NAME OF CLERGYMAN

NAME OF MINISTER

NAME OF CHURCH

NAME OF CEMETERY

NAME OF CLERGYMAN

NAME OF MINISTER

NAME OF CHURCH

NAME OF CEMETERY

162

M.D. 11/23/45

50-10237 50-24789

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10237

Registered No.

1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH	
Baby Boy Spears - Consuella		Nov. 18, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
B. FULL NAME OF (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Avenue		A. STATE Maryland B. COUNTY	
C. Length of stay in Baltimore		C. CITY OR TOWN (If outside corporate limits, give RURAL and give township) Baltimore	
Life		D. STREET ADDRESS (If rural, give location) 1225 Mc Culloh St.	
5. SEX M	6. COLOR OR RACE N	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH Nov. 17, 1950
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		9. AGE (In years last birthday) 1	
10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Wilbert Spears		12. CITIZEN OF WHAT COUNTRY?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		14. MOTHER'S MAIDEN NAME Consuella White	
16. SOCIAL SECURITY NO.		17. INFORMANT Baltimore City Hospitals Records : 4940 Eastern Avenue	

18. 762.5 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	CAUSE OF DEATH	INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES	(A) Prematurity DUE TO	Life
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B) Fetal atelectasis DUE TO	Life
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	(C)	

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 11-17, 1950 to 11-18, 1950, that I last saw the deceased alive on 11-18, 1950, and that death occurred at 6.45 a.m., from the causes and on the date stated above.					
23A. SIGNATURE J. P. Rogers		23B. ADDRESS 4940 Eastern Avenue		23C. DATE SIGNED 11-28-50	
24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY Holy Sepulchre		24D. LOCATION (City, town, or county) (State)	
DATE RECEIVED BY LOCAL REGISTRAR NOV 30 1950		REGISTRAR'S SIGNATURE Washington Williams, M.D.		25. FUNERAL DIRECTOR ADDRESS	

50-10271

CERTIFICATE OF DEATH

50-10271

Blank certificate form with horizontal lines for text entry.

600
50-10238
BIRTH NO.BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50-10238
Registered No.

1. NAME OF DECEASED (Type or Print) RUSSELL WRAY		2. DATE OF DEATH November 28, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore	
B. FULL NAME OF HOSPITAL OR INSTITUTION St. Agnes Hospital		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore Co Md	
C. Length of stay in Baltimore		D. STREET ADDRESS (If rural, give location) 2408 Estelle Avenue	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Feb 3 1902
9A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steel Worker		9B. KIND OF BUSINESS OR INDUSTRY Beth Steel (M)	9. AGE (In years last birthday) 48
10. FATHER'S NAME John E. Wray		11. BIRTHPLACE (State or foreign country) Pa	
12. WAS DECEASED EVER IN U.S. ARMED FORCES (If yes, give war or dates of service)		13. CITIZEN OF WHAT COUNTRY?	
14. SOCIAL SECURITY NO.		15. MOTHER'S MAIDEN NAME Bessie Keisletter	
16. INFORMANT Mrs. Rose Wray		17. ADDRESS Estelle Ave	

18. E816.4 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Crushed chest DUE TO	CAUSE OF DEATH (A) Crushed chest (B) Compound comminuted fracture of right femur and fracture of left femur (C)	INTERVAL BETWEEN ONSET AND DEATH
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Route 40, 4 mi. west of Ellicott City		
21D. TIME (Month) (Day) (Year) (Hour) November 28, 1950 4 P m.	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21F. HOW DID INJURY OCCUR? Passenger in auto and auto collision		
22. I certify that I took charge of the remains described above, held an Insp. & Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input checked="" type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .				
23A. SIGNATURE William Wray		23B. CHIEF MEDICAL EXAMINER..... M.D. ASSISTANT MEDICAL EXAMINER..... MEDICAL INVESTIGATOR.....		23C. DATE SIGNED 11-29-50

24A. BURIAL, CREMATION, REMOVAL (Specify) Removal	24B. DATE Dec 1 1950	24C. NAME OF CEMETERY OR CREMATORY Bel Town	24D. LOCATION (City, town, or county) (State) Leawentown Pa
DATE RECEIVED BY LOCAL REGISTRAR NOV 30 1950		REGISTRAR'S SIGNATURE William Wray	25. FUNERAL DIRECTOR Ullrich & Sons Home 2008 Chelan
VS 151		862.2 6903A 170C	

CERTIFICATE OF DEATH

1-1938

1-1938

1-1938

1-1938

1-1938

1-1938

1-1938

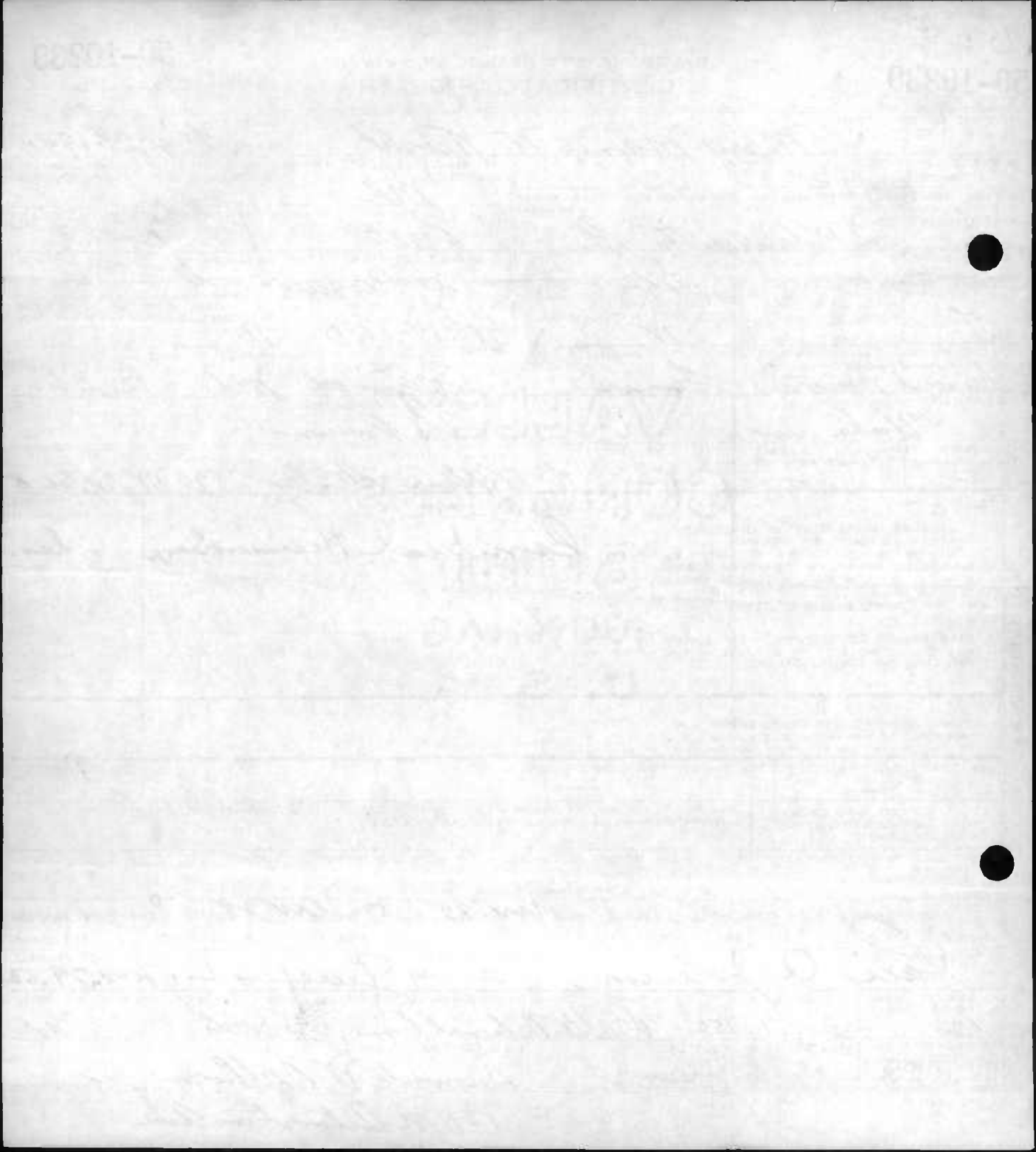
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623
50-10239
BIRTH NO.BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10239

Registered No.

1. NAME OF DECEASED (Type or Print) <i>Mary Mamie W. Wright</i>		2. DATE OF DEATH <i>Nov. 28-1950</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md</i> B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>721 Asquith St.</i>		C. CITY OR TOWN (If outside corporate limits write RURAL and give township) <i>Balto</i> <i>10-02</i>	
C. Length of stay in Baltimore <i>Life</i>		D. STREET ADDRESS (If rural, give location) <i>721 Asquith St.</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>C</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>W</i>	8. DATE OF BIRTH <i>Feb. 14-1880</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Funeral Director</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Funerals</i>	9. AGE (in years last birthday) <i>70</i>
11. BIRTHPLACE (State or foreign country) <i>Baltimore Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>Unknown</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Belma Stanley</i>		ADDRESS <i>2525 McCallister St.</i>	
18. <i>331X</i> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <i>Cerebral Hemorrhage</i> INTERVAL BETWEEN ONSET AND DEATH <i>6 hrs.</i> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION <i>0</i>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. HOW DID INJURY OCCUR?	
21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			
22. I hereby certify that I attended the deceased from <i>Nov. 22</i> , 19 <i>50</i> , to <i>Nov 28</i> , 19 <i>50</i> , that I last saw the deceased alive on <i>Nov 28</i> , 19 <i>50</i> , and that death occurred at <i>11</i> m., from the causes and on the date stated above.			
23A. SIGNATURE <i>Harry J. Sullivan, M.D.</i>		23B. ADDRESS <i>2329 Guilford L.</i>	
23C. DATE SIGNED <i>Nov. 29. 50</i>			
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>B.</i>		24B. DATE <i>Dec. 1-1950</i>	
24C. NAME OF CEMETERY OR CREMATORY <i>Balto. National Cem</i>		24D. LOCATION (City, town, or county) (State) <i>Balto. Md.</i>	
25. FUNERAL DIRECTOR <i>Samuel W. Sullivan Jr</i>		ADDRESS	



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630
50-10241BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10241

Registered No. _____

1. NAME OF DECEASED (Type or Print) BERTRAM HARDT		2. DATE OF DEATH Nov. 27, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY _____	
B. FULL NAME OF HOSPITAL OR INSTITUTION 2722 Silver Hill Ave.		C. CITY OR TOWN (If outside corporate limits, write R.R. and give township) Balto.	
c. Length of stay in Baltimore Yrs. _____ Mos. _____ Days _____		D. STREET ADDRESS (If rural, give location) 2722 Silver Hill Ave.	
5. SEX male	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH Oct. 14, 1893
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Butcher		10B. KIND OF BUSINESS OR INDUSTRY Retail Grocery	9. AGE (In years last birthday) 57
13. FATHER'S NAME Adam Hardt		11. BIRTHPLACE (State or foreign country) Maryland	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) yes		12. CITIZEN OF WHAT COUNTRY? Unknown	
16. SOCIAL SECURITY NO. World War I		14. MOTHER'S MAIDEN NAME Unknown	
17. INFORMANT Mr. David Cline - 2102 South Rd.		ADDRESS Mr. David Cline - 2102 South Rd.	
18. 480X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) - Acute Broncho-Pneumonia DUE TO (B) - Gynec DUE TO (C) - Acute Cardiac Failure INTERVAL BETWEEN ONSET AND DEATH 24 hrs. 3 days 2 hrs.			
19. DATE OF OPERATION None		19b. MAJOR FINDINGS OF OPERATION None	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) <input type="checkbox"/>	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <input type="checkbox"/>		21D. TIME (Month) (Day) (Year) (Hour) INJURY m. _____	
21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <input type="checkbox"/>	
22. I hereby certify that I attended the deceased from 11/25 , 19 50 , to Nov. 27 , 19 50 , that I last saw the deceased alive on Nov. 27 , 19 50 and that death occurred at 7:45 P. m., from the causes and on the date stated above.			
23A. SIGNATURE Earl L. Chambers		23B. ADDRESS 4108 Liberty Hts C	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/1/50	
24C. NAME OF CEMETERY OR CREMATORY Woodlawn Cem.		24D. LOCATION (City, town, or county) (State) Woodlawn, Md.	
DATE RECEIVED BY LOCAL REGISTRAR NOV 30 1950		REGISTRAR'S SIGNATURE Wm. J. Tichauer	
VS 150		25. FUNERAL DIRECTOR Wm. J. Tichauer & Sons - Balto	
		ADDRESS 033a Md.	

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STANDARD FORM NO. 64

STANDARD FORM NO. 64

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500
0-10242BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50-10242

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

CHARLES L. REIN

2. DATE
OF
DEATH Nov. 28, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION

3116 Belmont Ave.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence
A. STATE B. COUNTY before admission)

Md.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3116 Belmont Ave.

C. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

male

6. COLOR OR RACE

white

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)
married

8. DATE OF BIRTH

July 14, 1886

9. AGE (In years
last birthday)

64

If Under 1 Year
Months: Days Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Mgr. - Repair Dept.

10B. KIND OF BUSINESS OR
INDUSTRY

Silversmiths

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

John J. Rein

14. MOTHER'S MAIDEN NAME

Louise Herguth

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.17. INFORMANT ADDRESS
Mrs. Charles L. Rein 3116 Belmont Ave.

18. 163X I CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A)
DUE TO

Carcinoma Lung

INTERVAL BETWEEN
ONSET AND DEATH

6 mo.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B)
DUE TO
(C)II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH21B. PLACE OF INJURY (e.g., in or
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
INJURY

21E. INJURY OCCURRED

m. WHILE AT ☐ NOT WHILE
WORK AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov 27, 1950, to Nov 28, 1950, that I last saw the
deceased alive on Nov 27, 1950, and that death occurred at 4:30 A.M., from the causes and on the date stated above.

23A. SIGNATURE

R. Bradley Langhastley M.D.

23B. ADDRESS

3033 W. North Ave

23C. DATE SIGNED

11-29-50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

12/1/50

24C. NAME OF CEMETERY OR CREMATORY

Lorraine Cem.

24D. LOCATION (City, town, or county)

Woodlawn, Md.

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Thurston Williams, M.D.

25. FUNERAL DIRECTOR

Thos. J. Pickens & Sons - Balto
Md.

ADDRESS

VS 150

29032

047d

MEDICAL CERTIFICATION

50-10348

5-1108-5

58

50-10348

50-10348

50-10348

50-10348

50-10348

50-10348

50-10348

50-10348

50-10348

50-10348

325
N.D.143324
50-10243
BIRTH NO.BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10243

Registered No.

1. NAME OF DECEASED (Type or Print) Ruth May Hudson		2. DATE OF DEATH Nov. 29, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION Baltimore City Hospitals 4940 Eastern Avenue		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore	
c. Length of stay in Baltimore Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) 2232 Pennsylvania Ave. (17)	
5. SEX F	6. COLOR OR RACE N	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH May 1, 1918
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (in years last birthday) 32
13. FATHER'S NAME Charles Hudson		11. BIRTHPLACE (State or foreign country) N.C.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	12. CITIZEN OF WHAT COUNTRY?
14. MOTHER'S MAIDEN NAME Jessie Turner		17. INFORMANT Baltimore City Hospitals Records: 4940 Eastern Avenue	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Miliary Tuberculosis DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Lymphogranuloma Venereum OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			INTERVAL BETWEEN ONSET AND DEATH 9 Hours over 15 Years
19A. DATE OF OPERATION 11-15-50	19B. MAJOR FINDINGS OF OPERATION Biopsy lymph nodes of Revision of colostomy by excision; Lt. Axilla & rt. Groin		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 11-13, 1950, to 11-29, 1950, that I last saw the deceased alive on 11-29, 1950, and that death occurred at 3 a.m., from the causes and on the date stated above.			
23A. SIGNATURE J.S. Ogden		23B. ADDRESS 4940 Eastern Avenue	23C. DATE SIGNED 11-29-50
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial	24B. DATE 12-2-50	24C. NAME OF CEMETERY OR CREMATORY Mt. Calvary Cemetery	24D. LOCATION (City, town, or county) (State) Cedar Hill Md.
DATE RECEIVED BY LOCAL REGISTRAR NOV 30 1950	REGISTRAR'S SIGNATURE Wm. J. Williams	25. FUNERAL DIRECTOR Adolphus Halstead	ADDRESS 918 David Williams

Lungs involved. Information obtained from Bureau of Tuberculosis
report card. 2/1/51.

40
0-10244

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10244

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

EDWARD JOHN APPEL

2. DATE
OF
DEATH

Nov 29, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

Balto

B. FULL NAME OF
HOSPITAL OR
INSTITUTION

Mary Hospital

C. Length of stay in Baltimore

Life

Yrs.
Mos.
Days

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3219 Dudley Ave

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Feb 14, 1904

9. AGE (In years,
last birthday)

46

10. Under 1 Year
Months Days

11. Under 24 Hours
Hours Min.

10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Tuberculosis Mechanic

10B. KIND OF BUSINESS OR
INDUSTRY

REPAIRS

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

John Appel

14. MOTHER'S MAIDEN NAME

Elizabeth Soellner

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

Unknown

16. SOCIAL
SECURITY NO.

212-01-7784

17. INFORMANT

ADDRESS

Wife, Baltimore Ind.

18. 420.1

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A)

Coronary Insufficiency

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

Cardiac Hypertrophy &
Dilatation

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

Arteriosclerotic C. V. Disease

INTERVAL BETWEEN
ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

None

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov. 23, 1950, to Nov. 29, 1950, that I last saw the deceased alive on Nov. 29, 1950, and that death occurred at 3:05 p.m., from the causes and on the date stated above.

23A. SIGNATURE

Philip W. Neuman, M.D.

23B. ADDRESS

Mary Hospital

23C. DATE SIGNED

11/29/50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

Dec 2-50

24C. NAME OF CEMETERY OR CREMATORY

Holy Redeemer Balto

24D. LOCATION (City, town, or county)

Balto

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

William H. Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

Joseph Herr + Son

VS 150

55184 3001 1 Centurys any 893d

MEDICAL CERTIFICATION

100-1011

UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D. C. 20535

100-1011

[Faint, mostly illegible text covering the body of the document, possibly a letter or report. The text is too light to transcribe accurately.]

120

B-326

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10245

Registered No.

50-10245

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <i>Immie Boettger-Bavis</i>		2. DATE OF DEATH <i>Nov 27-50</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <i>Balto</i>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Ind</i> B. COUNTY	
5. FULL NAME OF HOSPITAL OR INSTITUTION <i>3811 Belair Rd</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Balto</i> <i>26-05</i>	
C. Length of stay in Baltimore <i>Life</i>		D. STREET ADDRESS (If rural, give location) <i>3811 Belair Rd</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Wed. widowed</i>	8. DATE OF BIRTH <i>OCT 26-1872</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House Wife</i>		10B. KIND OF BUSINESS OR INDUSTRY	
13. FATHER'S NAME <i>John F. Bracken</i>		14. MOTHER'S MAIDEN NAME <i>Not known</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Mrs. Elsie Hayes</i>		ADDRESS <i>3811 Belair Rd</i>	
18. <i>441X</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH (A) <i>Acute pulmonary Edema</i> DUE TO <i>Malignant hypertension Cardio-vascular disease</i> DUE TO <i>Arteriosclerosis - Myocarditis</i> (C)	
19A. DATE OF OPERATION <i>0</i>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR? <i>Twenty seventh</i>			
22. I hereby certify that I attended the deceased from <i>Jan 4</i> , 1943 to <i>Nov. 27</i> , 1950, that I last saw the deceased alive on <i>Nov. 27</i> , 1950, and that death occurred at <i>5:15 Am.</i> , from the causes and on the date stated above.			
23A. SIGNATURE <i>H. V. Harbold</i>		23B. ADDRESS M. D. <i>4706 Harford Road</i>	
23C. DATE SIGNED <i>11/29/50</i>			
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>Nov 30-50</i>	
24C. NAME OF CEMETERY OR CREMATORY <i>New Cathedral</i>		24D. LOCATION (City, town, or county) (State) <i>Balto</i>	
DATE RECEIVED BY LOCAL REGISTRAR <i>NOV 30 1950</i>		REGISTRAR'S SIGNATURE <i>Huntington Williams, Jr.</i>	
25. FUNERAL DIRECTOR <i>Josef Hair & Son</i>		ADDRESS <i>3001 Kentucky av</i> <i>093d</i>	

Harbale
4906 Harbale Rd

2-1519

L-420
50-10246BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED
(Type or Print)

Annie Lawless

2. DATE
OF
DEATH

11/28/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION

St. Agnes Hospital

C. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Domestic

10B. KIND OF BUSINESS OR
INDUSTRY

at home

13. FATHER'S NAME

William Lawless

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.4. USUAL RESIDENCE (Where deceased lived. If institution: residence
before admission)

A. STATE

B. COUNTY

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

25 Bishop Lane, Catonsville

8. DATE OF BIRTH

12/8/1870

9. AGE (In years
last birthday)

79

11 Under 1 Year
Months: Days11 Under 24 Hours
Hours: Min.

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF
WHAT COUNTRY?

14. MOTHER'S MAIDEN NAME

Annie Baker

17. INFORMANT

Mrs. Chas. Lawless

ADDRESS

18. 197X and E903.0

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

① Acute Congestive Heart Failure 1 wk.

② Generalized Osteoarthritis.

③ Rhabdomyosarcoma - left 4 yrs.

④ Gluteal region.

④ Fract. neck left Femur - 29 days

II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

As above. DR. John R. Davis

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

11-2-50; 11-4-50

Fract. neck Rt. Femur; Rhabdomyosarcoma.

21A. ACCIDENT WAS UNDER-
LYING OR CONTRIBUTING
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., io or
about home, farm, factory, street, office bldg., etc.)

at home.

21C. WHERE DID
INJURY OCCUR?

at home. Catonsville, Md.

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

10-30-50

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR?

Pt. fell while walking.

22. I hereby certify that I attended the deceased from 11-1-1950 to 11-28-1950, that I last saw the
deceased alive on 11-28-50, and that death occurred at 3:15 P.m., from the causes and on the date stated above.

23A. SIGNATURE

Cuthbert T. Hulse

M. D.

23B. ADDRESS

St. Agnes Hosp.

23C. DATE SIGNED

11-28-50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

12/2/50

24C. NAME OF CEMETERY OR CREMATORY

New Cathedral

24D. LOCATION (City, town, or county)

Baltimore City

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

NOV 30 1950

REGISTRAR'S SIGNATURE

Huntington Williams

25. FUNERAL DIRECTOR

Mac Nabbs, Son

ADDRESS

Catonsville 28 0552

100-10000

8-17-1958

H160
50-10247BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50-10247
Registered No.

1. NAME OF DECEASED (Type or Print)		LEONARD R. HUBER		2. DATE OF DEATH November 30, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY			
B. FULL NAME OF HOSPITAL OR INSTITUTION Maryland General Hospital		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore			
c. Length of stay in Baltimore Life Time		D. STREET ADDRESS (If rural, give location) 1726 Holmestead Street 9-07			
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH Oct 10 1889	9. AGE (In years last birthday) 61	10. Under 1 Year Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ELECTRICIAN		10B. KIND OF BUSINESS OR INDUSTRY Kopper Co		11. BIRTHPLACE (State or foreign country) Baltimore Md	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Michael L Huber		14. MOTHER'S MAIDEN NAME Katherine Baker	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 219-01-2631		17. INFORMANT ADDRESS Nellie Huber 1726 Homestead St.	
18. E 902-3 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Pulmonary atelectasis DUE TO ANTECEDENT CAUSES Fat embolism DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) industrial		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Bethlehem Steel Company	
21D. TIME (Month) (Day) (Year) (Hour) June 23, 1950 3.20 p. m.		21E. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? Fractured leg when he fell from pole on which he was working (15 feet)	
22. I certify that I took charge of the remains described above, held an Autopsy thercon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input checked="" type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .					
23A. SIGNATURE Stanley J. Durlach		23B. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> MEDICAL INVESTIGATOR <input type="checkbox"/>		23C. DATE SIGNED Nov. 30, 1950	
24A. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 12/4/50		24C. NAME OF CEMETERY OR CREMATORY New Cathedral	
24D. LOCATION (City, town, or county) BALTIMORE MD		24E. FUNERAL DIRECTOR Chas F Evans		24F. ADDRESS 118 W. Mt Royal Ave	

MEDICAL CERTIFICATION

57-10975

RECEIVED - CIVIL RIGHTS DIVISION

U.S. DEPARTMENT OF JUSTICE

57-10975

[Faint, mostly illegible text covering the majority of the page, likely a memorandum or report.]

P-620

50-10248

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10248

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Anne A. Parks

2. DATE
OF
DEATH

II-29-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution; residence

A. STATE

Maryland

B. COUNTY

City

before admission)

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR INSTITUTE 1703 Hope Street

C. CITY OR TOWN

Baltimore

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

1703 Hope Street

c. Length of stay in Baltimore

Life

Yrs.
Mos.
Days

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)
Married

8. DATE OF BIRTH

April 17th., 1905

9. AGE (In years
last birthday)

45

10 Under 1 Year
Months: Days Hours: Min.

7

12

10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR
INDUSTRY

Own Home

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Peter Dempsey

14. MOTHER'S MAIDEN NAME

Catherine Sheridan

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

None

16. SOCIAL
SECURITY NO.
None

17. INFORMANT

Mr. Wilmer G. Parks-1703 Hope Street

ADDRESS

18. 442X

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A)

Hypertensive Heart Dis.

4 years

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e.g., in or
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m.

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐22. I hereby certify that I attended the deceased from April 5, 1948 to Nov. 29, 1950, that I last saw the
deceased alive on Nov 28, 1950, and that death occurred at 5:30 m., from the causes and on the date stated above.

23A. SIGNATURE

Sol Smith

M. D.

23B. ADDRESS

1223 E. North Ave

23C. DATE SIGNED

11/29/50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)
Burial

24B. DATE

Dec. 2, 1950

24C. NAME OF CEMETERY OR CREMATORY

Most Holy Redeemer

24D. LOCATION (City, town, or county)

Belair Rd. Balto; Md.

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

George J. Ruth, Inc. 1735 Harford Avenue

NOV 30 1950

VS 150

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80-10318

STATE OF NEW YORK
OFFICE OF THE ATTORNEY GENERAL

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50-10249

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10249

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Samuel S. Mills

2. DATE
OF
DEATH

Nov. 28, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

116 S. Haven St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

116 S. Haven St.

B. FULL NAME OF
HOSPITAL OR
INSTITUTION
(If not in hospital or institution, give street address or location)

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Balto. Md.

D. STREET ADDRESS (If rural, give location)

116 S. Haven St

c. Length of stay in Baltimore

life

Yrs.
Mos.
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Nov. 14, 1881

9. AGE (In years,
last birthday)

69

If Under 1 Year
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Watchman

10B. KIND OF BUSINESS OR
INDUSTRY

Kimble & Tyler Co.

11. BIRTHPLACE (State or foreign country)

Balto. Md.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

WOODEN BAREW (M)
Wm. Mills

14. MOTHER'S MAIDEN NAME

Sarah Tyler

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) Hardening of Arteries
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) High blood pressure, result-
DUE TO ing in cardiac decompensation
consequent pulmonary edema

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22. I hereby certify that I attended the deceased from January, 1948 to Nov. 24, 1950 that I last saw the deceased alive on Nov. 27, 1950 and that death occurred at 7: P m., from the causes and on the date stated above.

23A. SIGNATURE

Allen C. Beetham

23B. ADDRESS

M. D.

3139 E. Beetham St.

23C. DATE SIGNED

Nov. 30-50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

Dec. 1, 1950

24C. NAME OF CEMETERY OR CREMATORY

Baltimore Cem.

24D. LOCATION (City, town, or county)

Balto. Md.

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

OV 301950

William J. Williams

Phyllis H. Williams

2024 Orleans St.

VS 150

76332

93D

MEDICAL CERTIFICATION

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01501-02

RECEIVED
U.S. DEPARTMENT OF AGRICULTURE
WASHINGTON, D.C.

TO: [illegible]
FROM: [illegible]
SUBJECT: [illegible]

[Faint, illegible handwritten text]

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N. D.- 143583

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50-10250
Registered No.

BIRTH NO. 50-10250

1. NAME OF DECEASED
(Type or Print)

James Edward Spencer

2. DATE
OF
DEATH

Nov 29, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland Balto. City

B. FULL NAME OF
HOSPITAL OR
INSTITUTION (If not in hospital or institution, give street address or location)Baltimore City Hospitals
4940 Eastern Avenue

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

Maryland

B. COUNTY

before admission)

C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1936 Jefferson Street (2) 7-05

c. Length of stay in Baltimore

10 Years
Mos.
Days

5. SEX

Male

6. COLOR OR RACE

Negro

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Oct. 2, 1919

9. AGE (In years

last birthday)

31

If Under 1 Year

Months: Days

If Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Chauffeur

10B. KIND OF BUSINESS OR INDUSTRY

Private

11. BIRTHPLACE (State or foreign country)

North Carolina

12. CITIZEN OF WHAT COUNTRY?

U.S.A

13. FATHER'S NAME

Ernest Spencer

14. MOTHER'S MAIDEN NAME

Bertha Pittman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)

No

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

246-16-4714

17. INFORMANT

Records: Baltimore City Hospitals
4940 Eastern Avenue

ADDRESS

18.

002X I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

Far Advanced Bilateral Pulmonary

DUE TO

Tuberculosis

3 Mos?

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT WORK ☐NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11-22, 19 50, to 11-29, 19 50, that I last saw the deceased alive on 11-29, 19 50, and that death occurred at 9:40 AM, from the causes and on the date stated above.

23A. SIGNATURE

[Signature]

M. D.

23B. ADDRESS

4940 Eastern Avenue

23C. DATE SIGNED

11-29-50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

12/2/1950

24C. NAME OF CEMETERY OR CREMATORY

Mt Calvary Cem.

24D. LOCATION (City, town, or county)

Brooklyn Md

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

[Signature]

25. FUNERAL DIRECTOR

ADDRESS

[Signature] 1000 E. North Ave

VS 150

6828A

12 B

MEDICAL CERTIFICATION

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BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10251

Registered No.

1. NAME OF DECEASED (Type or Print) Frank W. Palmer			2. DATE OF DEATH Nov. 28, 1950		
3. PLACE OF DEATH: A. Baltimore City, Maryland 528 Arlington ave.			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) B. COUNTY 18-01		
B. FULL NAME OF HOSPITAL OR INSTITUTION			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto.		
c. Length of stay in Baltimore Life			D. STREET ADDRESS (If rural, give location) 414 N. Fremont ave.		
5. SEX Male	6. COLOR OR RACE Colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 1892	9. AGE (In years last birthday) 58 yrs	10. Under 1 Year Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook			10B. KIND OF BUSINESS OR INDUSTRY Rest.		
11. BIRTHPLACE (State or foreign country) Balto.			12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME Henry Palmer			14. MOTHER'S MAIDEN NAME Laura Chandler		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)			16. SOCIAL SECURITY NO.		
17. INFORMANT Arnelia Boyer			ADDRESS 528 Arlington ave.		

18. 331X I		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) Cerebral Hemorrhage		2 days	
ANTECEDENT CAUSES		(B) Hypertension			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					

19A. DATE OF OPERATION 0		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Nov 26 , 1950, to Nov 27 , 1950, that I last saw the deceased alive on Nov 27 , 1950, and that death occurred at 10:30 A.M. , from the causes and on the date stated above.					
23A. SIGNATURE Dr. H. G. Gutter		M. D. 1215 Pennsylvania Ave		23C. DATE SIGNED 11/29/50	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE Dec 1-50		24C. NAME OF CEMETERY OR CREMATORY Mt Auburn	
24D. LOCATION (City, town, or county) (State) Balto.		25. FUNERAL DIRECTOR James E. Anderson			
DATE RECEIVED BY LOCAL REGISTRAR DEC 1 - 1950		REGISTRAR'S SIGNATURE William M. Williams		ADDRESS 638 N. 7th St.	

VS 150

754 614

83a

MEDICAL CERTIFICATION

[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page. The text appears to be a letter or report, possibly dated 1880, mentioning "United States Department of the Interior" and "Bureau of Land Management".]

To Be Approved by
Chief Medical Examiner

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10252

Registered No.

1. NAME OF DECEASED (Type or Print) Russell Rowley		2. DATE OF DEATH November 30, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland G.O.R. - Hq 1		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Michigan B. COUNTY V-19	
B. FULL NAME OF HOSPITAL OR INSTITUTION JOHNS HOPKINS HOSPITAL		C. CITY OR TOWN North Branch (If outside corporate limits, write RURAL and give township)	
c. Length of stay in Baltimore		D. STREET ADDRESS (If rural, give location) Rt. #2	
5. SEX male	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH 5-12-22
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country) Michigan	
10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME Austin Rowley		14. MOTHER'S MAIDEN NAME Mary Shuck	
15. WAS DECEASED EVER IN U. S. ARMED FORCES (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
		17. INFORMANT JOHNS HOPKINS HOSPITAL ADDRESS	

18. 754.5 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Hemorrhage during operation	CAUSE OF DEATH Hemorrhage during operation	INTERVAL BETWEEN ONSET AND DEATH 3 hrs.
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. rupture of aortic anastomosis following resection of coarctation	DUE TO rupture of aortic anastomosis following resection of coarctation	10d.
Coarctation of aorta	DUE TO Coarctation of aorta	Congenital
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Septicemia due to B. pyocyaneus		10d.

19A. DATE OF OPERATION 11-21-50 11-30-50	19B. MAJOR FINDINGS OF OPERATION Coarctation of aorta (1). Rupture of aorta (2)	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) Hospital	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Johns Hopkins Hospital
21D. TIME (Month) (Day) (Year) (Hour) November 30, 1950 ? m.	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21F. HOW DID INJURY OCCUR? operation Therapeutic misadventure, died during
22. I hereby certify that I attended the deceased from 11-14 , 19 50 , to 11-30 , 19 50 , that I last saw the deceased alive on 11-30 , 19 50 , and that death occurred at 4:50 P.M. , from the causes and on the date stated above.		
23A. SIGNATURE AB Morrow	23B. ADDRESS JOHNS HOPKINS HOSPITAL	23C. DATE SIGNED 11-30-50

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial	24B. DATE Dec 1 1950	24C. NAME OF CEMETERY OR CREMATORY North Branch Mich	24D. LOCATION (City, town, or county) (State) 4905 5400 York Road
DATE RECEIVED BY LOCAL REGISTRAR DEC 1 - 1950	REGISTRAR'S SIGNATURE William M. Williams	25. FUNERAL DIRECTOR Henry J. Jones	

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Johnston, William
1841

536
50-10253BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50-10253

1. NAME OF DECEASED (Type or Print) MORRIS SNYDER			2. DATE OF DEATH 11/30/1950		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 15-12		
B. FULL NAME OF HOSPITAL OR INSTITUTION 2526 KEYWORTH AVE			C. CITY OR TOWN (If outside corporate limits, give RURAL and give township) BALTIMORE		
c. Length of stay in Baltimore 48 Yrs. Mos. Days			D. STREET ADDRESS (If rural, give location) 2526 KEYWORTH AVE		
5. SEX MALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH 68		9. AGE (in years last birthday) 68
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED MERCHANT GROCERY (A)			11. BIRTHPLACE (State or foreign country) RUSSIA		12. CITIZEN OF WHAT COUNTRY? U.S.A
13. FATHER'S NAME ALEXANDER			14. MOTHER'S MAIDEN NAME SARAH		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.			
17. INFORMANT ABE SNYDER			ADDRESS 3727 COLUMBUS DR.		

18. 193X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Carcinoma of Right lung DUE TO Carcinoma of brain DUE TO — DUE TO —	CAUSE OF DEATH Carcinoma of Right lung Carcinoma of brain	INTERVAL BETWEEN ONSET AND DEATH
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION 0		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 10/15, 1949 to 11/29, 1950 , that I last saw the deceased alive on 11/29, 1950 , and that death occurred at 11A m., from the causes and on the date stated above.					
23A. SIGNATURE G.H. Hornstein		23B. ADDRESS 204 E. Biddle ST		23C. DATE SIGNED 11/30/50	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/30/1950		24C. NAME OF CEMETERY OR CREMATORY Mt Carmel	
24D. LOCATION (City, town, or county) (State) Balto. Md.		24E. FUNERAL DIRECTOR Jack Lewis Inc.		24F. ADDRESS 2100 Eutan PL	
DATE RECEIVED BY LOCAL REGISTRAR DEC 1 - 1950		REGISTRAR'S SIGNATURE W. H. Williams, Jr.		25. FUNERAL DIRECTOR Jack Lewis Inc.	

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0-10254BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50-10254
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

LAURA ELIZABETH LEWIS

2. DATE
OF
DEATH Nov. 29, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR INSTITUTION Methodist Home for the Aged

2211 W. Rogers Ave.

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE Md.C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore 27-15

D. STREET ADDRESS (If rural, give location)

2211 W. Rogers Ave.

C. Length of stay in Baltimore

Yrs.
Mos.
Days5. SEX
female6. COLOR OR RACE
white7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)
single8. DATE OF BIRTH
Aug. 22, 18729. AGE (In years,
last birthday) 78
If Under 1 Year Months Days
If Under 24 Hours Hours Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)
none10B. KIND OF BUSINESS OR
INDUSTRY11. BIRTHPLACE (State or foreign country)
Maryland12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

George W. Lewis

14. MOTHER'S MAIDEN NAME

Laura S. Barton

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)
no16. SOCIAL
SECURITY NO.17. INFORMANT ADDRESS
Miss Miriam O. Coates, 2211 W. Rogers Ave.

18. 422.1 I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)(A) Myocardial Insufficiency
DUE TO

4 days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) Arteriosclerosis
DUE TO

10 yrs.

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May 15, 1950, to Nov 29, 1950, that I last saw the deceased alive on Nov 28, 1950, and that death occurred at 4:35 P. M., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)
Burial24B. DATE
12/2/5024C. NAME OF CEMETERY OR CREMATORY
Loudon Park Cem.24D. LOCATION (City, town, or county) (State)
Balto., Md.DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

DEC 1 - 1950

26. J. Pickens & Son - Balto Md.

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624
50-10255

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50-10255

1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH	
AMANDA M. MARSHALL		Nov. 30, 1950	
3. PLACE OF DEATH: a. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
b. FULL NAME OF HOSPITAL OR INSTITUTION 2504 Roslyn Ave.		a. STATE Md.	
c. Length of stay in Baltimore		c. CITY OR TOWN Baltimore	
5. SEX female		d. STREET ADDRESS (If rural, give location) 2504 Roslyn Ave.	
6. COLOR OR RACE white		8. DATE OF BIRTH Sept. 1, 1863	
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) widowed		9. AGE (In years last birthday) 87	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		11. BIRTHPLACE (State or foreign country) Maryland	
10b. KIND OF BUSINESS OR INDUSTRY at home		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Edward Townsend		14. MOTHER'S MAIDEN NAME Amanda Brown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT		ADDRESS	
Miss Florence Marshall - 2504 Roslyn Ave.			

18. CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH about 5 years
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) cardio vascular disease DUE TO		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) arterio sclerosis DUE TO		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. (C)		?

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) None		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) about home		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from Oct. 20, 1950 to Nov. 29, 1950 that I last saw the deceased alive on Nov. 29, 1950, and that death occurred at 6:30 AM from the causes and on the date stated above.

23A. SIGNATURE: *Charles Drabbe* M. D. 23B. ADDRESS: 2220 Garrison Blvd. 23C. DATE SIGNED: Nov. 30, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/3/50		24C. NAME OF CEMETERY OR CREMATORY Methodist Cemetery		24D. LOCATION (City, town, or county) (State) Pocomoke City, Md.	
DATE RECEIVED BY LOCAL REGISTRAR DEC 1-1950		REGISTRAR'S SIGNATURE <i>William M. Williams</i>		25. FUNERAL DIRECTOR <i>Wm. J. Tolener</i>		ADDRESS Baeto, Md.	

93

WATER
ON GREESE
B. G. H. D.
H. C. H. A. G.
S. V. A.

625
50-10256BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50-10256

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH	
		CHARLOTTE (Lillie) MORGAN		Nov 29, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland 2117 DENISON ST		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY			
B. FULL NAME OF HOSPITAL OR INSTITUTION Crawford Retreat		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore			
c. Length of stay in Baltimore		D. STREET ADDRESS (If rural, give location) 5602 Park Heights Ave.			
5. SEX Female	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) widowed	8. DATE OF BIRTH Aug. 29, 1870	9. AGE (In years, last birthday) 80	10. Under 1 Year Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10B. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME Depser		14. MOTHER'S MAIDEN NAME ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) female		16. SOCIAL SECURITY NO. white		17. INFORMANT Miss D. M. Morgan	
				ADDRESS 5602 Park Heights Av	
18. 331X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH (A) Cerebral Arterio-vascular Accident 4 days DUE TO (B) Generalized Arteriosclerosis Arterio- DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION 0		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Nov. 27, 1950, to Nov 29, 1950, that I last saw the deceased alive on Nov 29, 1950, and that death occurred at 11:50 P. M., from the causes and on the date stated above.					
23A. SIGNATURE J. Bradley Laughery M.D.		23B. ADDRESS 3033 W. North Ave		23C. DATE SIGNED 11/29/50	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/2/50		24C. NAME OF CEMETERY OR CREMATORY Loudon Park	
		24D. LOCATION (City, town, or county) (State) Baltimore, Md.			
DATE RECEIVED BY LOCAL REGISTRAR DEC 1 - 1950		REGISTRAR'S SIGNATURE [Signature]		25. FUNERAL DIRECTOR Wm. J. Tichenor & Sons - Balto Md. 83a	

50-10225

CERTIFICATE OF DEATH

DECEASED (Name)

1-17-36

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1-17-36

256

EXNER

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50-10257

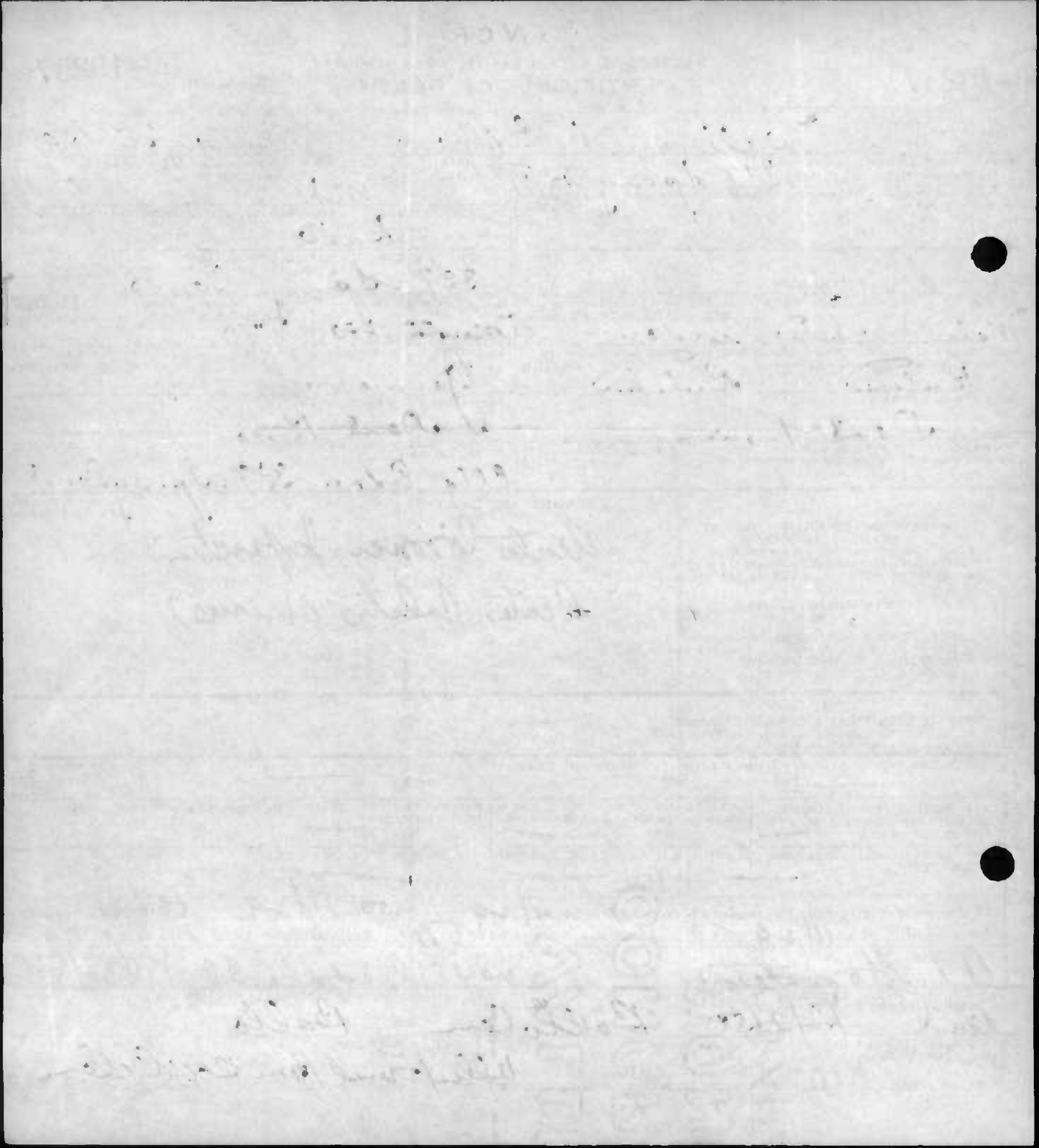
1. NAME OF DECEASED (Type or Print) <i>William R Exner</i>		2. DATE OF DEATH <i>Nov 30 1950</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <i>337 Spring Court</i>		4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) A. STATE <i>Md</i> B. COUNTY <i>X</i>	
B. FULL NAME OF HOSPITAL OR INSTITUTION		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Balto 3-01</i>	
c. Length of stay in Baltimore		D. STREET ADDRESS (If rural, give location) <i>337 Spring Court</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>widow</i>	8. DATE OF BIRTH <i>March 18 1870</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Butcher</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Butcher (A)</i>	9. AGE (in years last birthday) <i>70</i>
11. BIRTHPLACE (State or foreign country) <i>Germany</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Don't Know</i>		14. MOTHER'S MAIDEN NAME <i>Don't Know</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Ella Exner</i>		ADDRESS <i>337 Spring Court</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>470.1 I</i> CAUSE OF DEATH (A) <i>Acute Coronary Infarction</i> DUE TO (B) <i>Acute Colitis (Virus)</i> DUE TO (C) _____ INTERVAL BETWEEN ONSET AND DEATH		19. DATE OF OPERATION <i>0</i> 19b. MAJOR FINDINGS OF OPERATION	
19A. DATE OF OPERATION <i>0</i>		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I hereby certify that I attended the deceased from <i>11/29</i> , 19 <i>50</i> , to <i>11/29</i> , 19 <i>50</i> , that I last saw the deceased alive on <i>11/29</i> , 19 <i>50</i> , and that death occurred at <i>5A</i> a.m., from the causes and on the date stated above.	
23A. SIGNATURE <i>A. H. Hornstein</i>		23B. ADDRESS <i>204E. Biddle St</i>	
23C. DATE SIGNED <i>11/30/50</i>		23D. SIGNATURE	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Buried</i>		24B. DATE <i>12/2/50</i>	
24C. NAME OF CEMETERY OR CREMATORY <i>Balto Cem</i>		24D. LOCATION (City, town, or county) (State) <i>Balto</i>	
DATE RECEIVED BY LOCAL REGISTRAR <i>DEC 1 1950</i>		REGISTRAR'S SIGNATURE <i>James W. Williams, Jr.</i>	
25. FUNERAL DIRECTOR <i>Willard Funeral Home</i>		ADDRESS <i>2006 Calver</i>	

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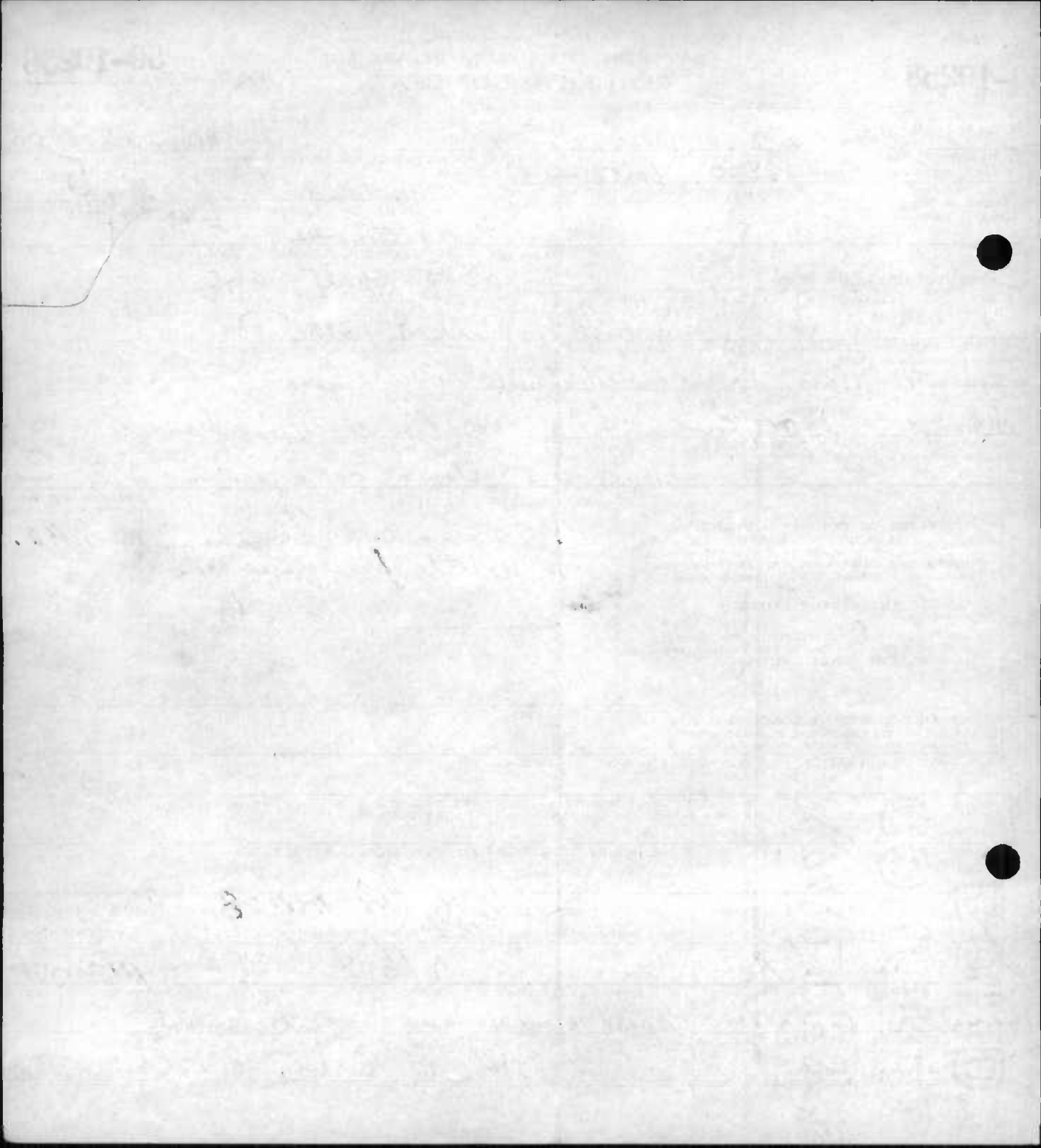
MEDICAL CERTIFICATION



622
50-10258GORCZEWICZ
BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50-10258

1. NAME OF DECEASED (Type or Print) <i>Stanley E. Gorczewicz</i>		2. DATE OF DEATH <i>Nov. 28 1950</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <i>6800 Fruit Ave</i>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>26-05</i>	
B. FULL NAME OF HOSPITAL OR INSTITUTION		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore</i>	
c. Length of stay in Baltimore <i>Life</i>		D. STREET ADDRESS (If rural, give location) <i>6800 Fruit Ave</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Married</i>	8. DATE OF BIRTH <i>April 9 1890</i>
9. AGE (In years last birthday) <i>60</i>		10. Under 1 Year Months: Days	
11. Under 24 Hours Hours: Min.		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Carpenter Helper</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Cross and Blackwell</i>	
13. FATHER'S NAME <i>Frank Gorczewski</i>		14. MOTHER'S MAIDEN NAME <i>Rosalie Badziankowski</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>215-05-6048</i>	
17. INFORMANT <i>Victorina Gorczewski</i>		ADDRESS <i>6800 Fruit Ave</i>	
18. <i>410X</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Coronary Thrombosis & Myocard Infarction</i>		CAUSE OF DEATH <i>Coronary Thrombosis & Myocard Infarction</i>	
INTERVAL BETWEEN ONSET AND DEATH <i>940.</i>			
19A. DATE OF OPERATION <i>0</i>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>Jan 16, 1949</i> to <i>Nov. 28, 1950</i> , that I last saw the deceased alive on <i>Nov. 28, 1950</i> , and that death occurred at <i>10:45</i> p.m., from the causes and on the date stated above.			
23A. SIGNATURE <i>John W. Weber</i>		23B. ADDRESS <i>1016 S East Ave</i>	
23C. DATE SIGNED <i>11/30/50</i>			
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>Dec 2 1950</i>	
24C. NAME OF CEMETERY OR CREMATORY <i>Sacred Heart of Mary</i>		24D. LOCATION (City, town, or county) (State) <i>Balta. County</i>	
DATE RECEIVED BY LOCAL REGISTRAR <i>DEC 1 - 1950</i>		REGISTRAR'S SIGNATURE <i>John W. Weber</i>	
25. FUNERAL DIRECTOR <i>John W. Weber</i>		ADDRESS <i>401 D. Chester Street</i>	



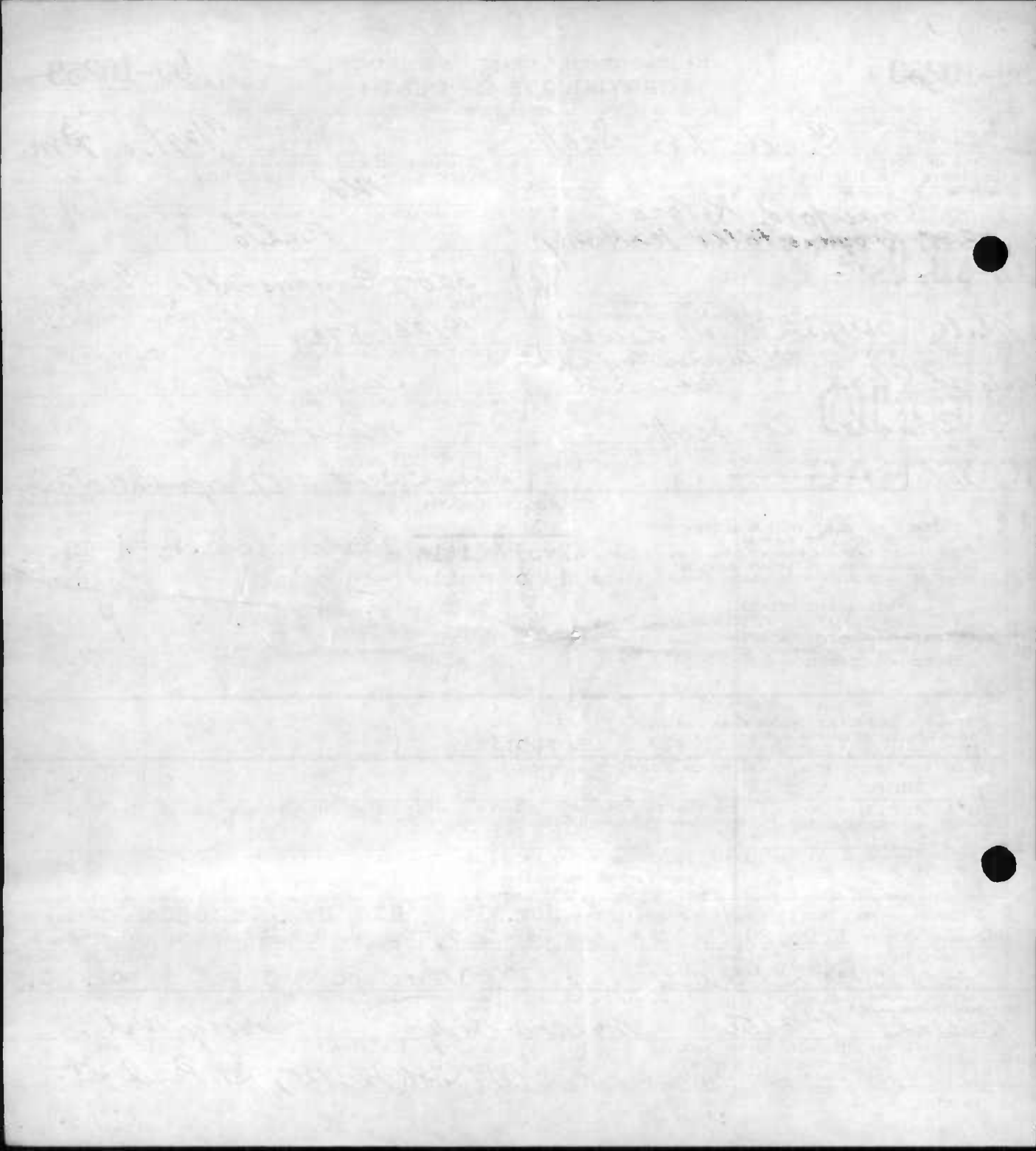
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50-10259

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

all 10 45
50-10259
Registered No.

1. NAME OF DECEASED (Type or Print) C. R. Lee Scott		2. DATE OF DEATH 11/29/50 3 P.M.	
3. PLACE OF DEATH: A. Baltimore City, Maryland 2117 DENISON ST		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE md B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION Crawford Retreat		C. CITY OR TOWN (If outside corporate limits, write full name and give township) Balto 15-47	
c. Length of stay in Baltimore Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) 3207 Gwynns Falls Pkwy	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH 10/26/1870
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Clerk		10B. KIND OF BUSINESS OR INDUSTRY B & O R.R.	9. AGE (In years last birthday) 80
11. BIRTHPLACE (State or foreign country) Balto. Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Charles A. Scott		14. MOTHER'S MAIDEN NAME Mary Deal	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Mary C. Scott		ADDRESS 3207 Gwynns Falls Pkwy	
18. 442 X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) Myocarditis XXXXXXXXXXXXXXXXXXXX DUE TO Hypo static pneumonia ANTECEDENT CAUSES (B) Arteriosclerosis DUE TO (C) OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. neuphritis			
19A. DATE OF OPERATION none		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Nov. 14 , 19 50 , to Nov. 28 , 19 50 that I last saw the deceased alive on Nov. 29 , and that death occurred at 2.55 pm from the causes and on the date stated above.			
23A. SIGNATURE Thelma D. Dye		23B. ADDRESS 2220 Garrison Blvd	
23C. DATE SIGNED Nov. 30. 50			
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial	24B. DATE 12/2/50	24C. NAME OF CEMETERY OR CREMATORY Meadow Ridge	24D. LOCATION (City, town, or county) (State) Dorsey Md.
DATE RECEIVED BY LOCAL REGISTRAR DEC 1 - 1950		REGISTRAR'S SIGNATURE Huntington Williams	
25. FUNERAL DIRECTOR Wm Cook Inc.		ADDRESS 1217 St. Paul St.	

MEDICAL CERTIFICATION



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50-10260

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10260
Registered No.

1. NAME OF DECEASED (Type or Print) Mary Alice Meadowcroft Chew		2. DATE OF DEATH Nov. 28, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 14-01	
B. FULL NAME OF HOSPITAL OR INSTITUTION 1432 Park Avenue		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore	
C. Length of stay in Baltimore		D. STREET ADDRESS (If rural, give location) 1432 Park Avenue	
5. SEX female	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) widowed	8. DATE OF BIRTH Dec. 21, 1860
9. AGE (in years last birthday) 89		10. Under 1 Year Months: Days 11. Under 24 Hours Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10B. KIND OF BUSINESS OR INDUSTRY own home	
11. BIRTHPLACE (State or foreign country) Chicago, Illinois		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Richard Meadowcroft		14. MOTHER'S MAIDEN NAME Mary Price	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) none		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mrs. Theodore W. Forbes, 1432 Park Avenue		ADDRESS	
18. 450.0 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Arteriosclerosis, general DUE TO (A) 74 ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) (C) OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		INTERVAL BETWEEN ONSET AND DEATH Several years	
19A. DATE OF OPERATION 0		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 10-23, 1950 to 11-28, 1950 , that I last saw the deceased alive on 11-27, 1950 and that death occurred at 3 PM , from the causes and on the date stated above.			
23A. SIGNATURE Joseph D.B. King		23B. ADDRESS 1210 Eastern Pkce	
23C. DATE SIGNED 11-30-50			
24A. BURIAL, CREMATION, REMOVAL (Specify) removal		24B. DATE 12/3/50	
24C. NAME OF CEMETERY OR CREMATORY Graceland		24D. LOCATION (City, town, or county) (State) Chicago, Illinois	
DATE RECEIVED BY LOCAL REGISTRAR DEC 1 - 1950		REGISTRAR'S SIGNATURE William M. Williams	
25. FUNERAL DIRECTOR Wm. Cook, Inc.		ADDRESS 1217 St. Paul Street	

MEDICAL CERTIFICATION

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530
50-10261

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10261
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) JOHN W. SMITH.			2. DATE OF DEATH NOVEMBER 28 1950		
3. PLACE OF DEATH: A. Baltimore City, Maryland BALTIMORE CITY.			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE BALTIMORE CITY MARYLAND. B. COUNTY		
5. FULL NAME OF HOSPITAL OR INSTITUTION 1109 MADISON AVE.			C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township) BALTIMORE CITY.		
c. Length of stay in Baltimore LIFE.			D. STREET ADDRESS (If rural, give location) 1109 MADISON AVE.		
5. SEX Male	6. COLOR OR RACE Colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Sept. 6, 1874	9. AGE (In years last birthday) 76	10. Under 1 Year Months: Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Caterer			11. BIRTHPLACE (State or foreign country) Del Mar, Delaware		
10B. KIND OF BUSINESS OR INDUSTRY Public			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME John W. Smith			14. MOTHER'S MAIDEN NAME Rhoda Smith		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. 216-09-8109		
17. INFORMANT Mrs. Lucy B. Smith			ADDRESS 1109 Madison Ave		

CAUSE OF DEATH

18. 177X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CARCINOMIA OF PROSTATE. JANUARY 5 1945 DUE TO	INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. METASTASSIS GENERAL. DUE TO	1947.
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. CHRONIC MYOCARDITIS. DUE TO	1945.

19A. DATE OF OPERATION JANY UARY 1945		19B. MAJOR FINDINGS OF OPERATION CARCINOMIA OF PROSTATE.		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from JANUARY 5, 1945 , to NOVEMBER 28 1950 last saw the deceased alive on NOV. 28, 1950 , and that death occurred at 1:45 P.M. from the causes and on the date stated above.					
23A. SIGNATURE <i>Charles J. Clanton</i>		23B. ADDRESS 3013 ST PAUL STREET.		23C. DATE SIGNED NOV 28 1950	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE Dec. 1, 1950		24C. NAME OF CEMETERY OR CREMATORY Mt Auburn Cem.	
24D. LOCATION (City, town, or county) Balto. Co.		25. FUNERAL DIRECTOR Holland Funeral Home-1631 Druid Hill Ave.			
DATE RECEIVED BY LOCAL REGISTRAR DEC 1 - 1950		REGISTRAR'S SIGNATURE <i>Wm. J. Williams</i>		ADDRESS	

51B

50-10801

CERTIFICATE OF DEATH

1-10-61

NAME OF DECEASED		DATE OF BIRTH		PLACE OF BIRTH	
SEX		RACE		RELIGION	
MARRIED		OCCUPATION		EDUCATION	
CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH	
DATE OF DEATH		TIME OF DEATH		HOUR OF DEATH	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF MINISTER	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	
PLACE OF SIGNATURE		PLACE OF SIGNATURE		PLACE OF SIGNATURE	
NAME OF DECEASED		DATE OF BIRTH		PLACE OF BIRTH	
SEX		RACE		RELIGION	
MARRIED		OCCUPATION		EDUCATION	
CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH	
DATE OF DEATH		TIME OF DEATH		HOUR OF DEATH	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF MINISTER	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	
PLACE OF SIGNATURE		PLACE OF SIGNATURE		PLACE OF SIGNATURE	

630
50-10262BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50-10262
Registered No. 50-10262

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Clarence E. Barth, Sr.		2. DATE OF DEATH Nov. 29, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION 1112 Montpelier St.		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore	
c. Length of stay in Baltimore - Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) 1112 Montpelier St.	
5. SEX Male	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) widowed	8. DATE OF BIRTH April 5, 1875
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Night Watchman		10B. KIND OF BUSINESS OR INDUSTRY Goodwill Industries	9. AGE (In years last birthday) 75
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Christian E. Barth		14. MOTHER'S MAIDEN NAME Anna Sindall	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) - (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. -	
17. INFORMANT Mrs. Margaret Smith-1112 Montpelier St.		ADDRESS	

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Rectal carcinoma (A) DUE TO	CAUSE OF DEATH	INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. (C) Metastasis in lungs		

19A. DATE OF OPERATION 1948	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **11-1-, 1950** to **11-29-, 1950**, that I last saw the deceased alive on **11-29, 1950** and that death occurred at **4:30P. m.**, from the causes and on the date stated above.

23A. SIGNATURE <i>Isaac Fisher</i>	23B. ADDRESS 1823 N. Washington St.	23C. DATE SIGNED 11-30-50
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24A. BURIAL, CREMATION, REMOVAL (Specify) Burial	24B. DATE 12-2-50	24C. NAME OF CEMETERY OR CREMATORY Loudon Park	24D. LOCATION (City, town, or county) (State) -
DATE RECEIVED BY LOCAL REGISTRAR 12-1-50	REGISTRAR'S SIGNATURE Huntington Williams, M.D.	25. FUNERAL DIRECTOR Mildred T. Blight-6009 Harford Rd.	ADDRESS

EXDWD
107KRA4
0

460
50-10263

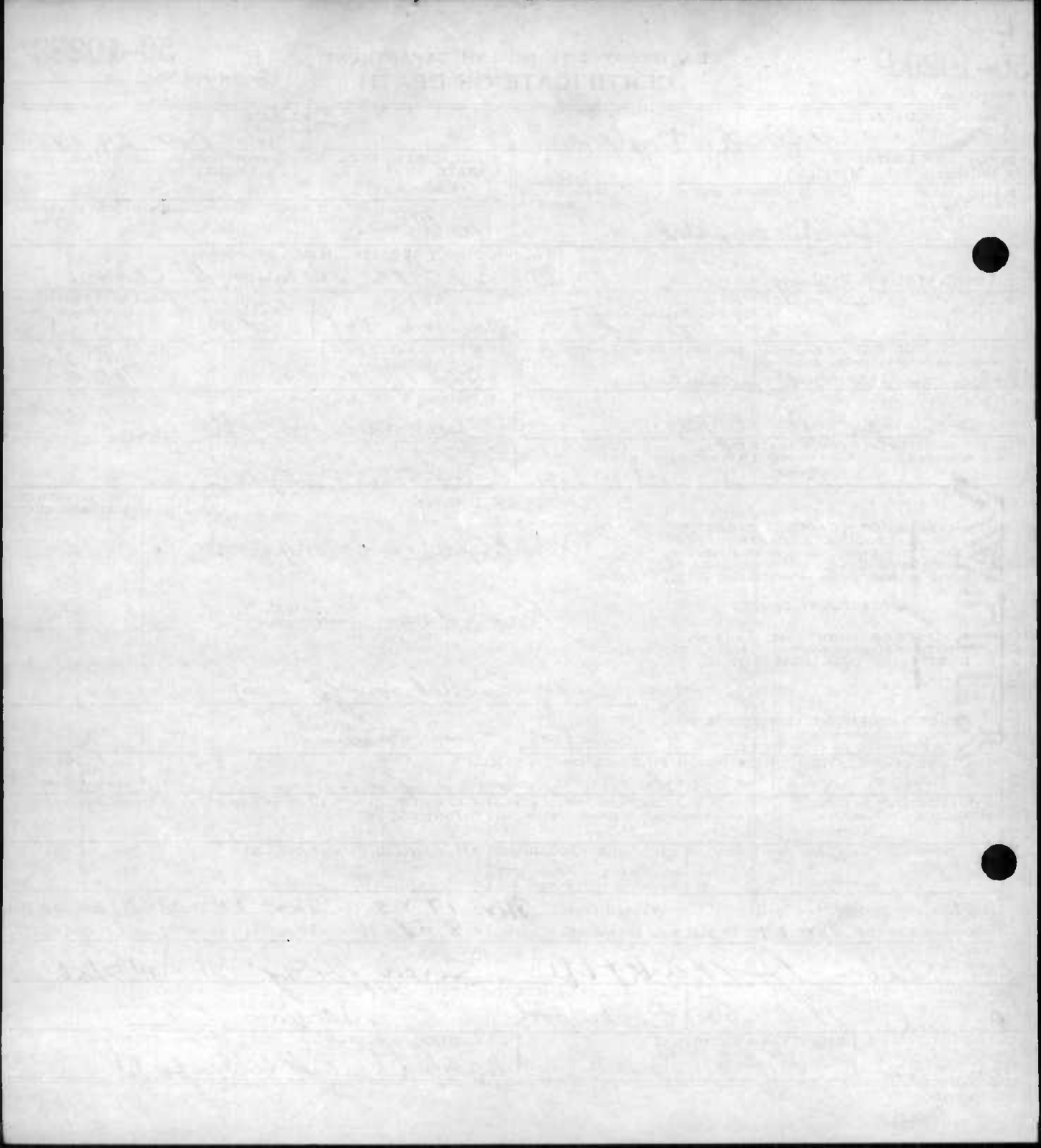
TYLER
BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10263

Registered No. _____

1. NAME OF DECEASED (Type or Print) <i>Albert A. Tyler</i>		2. DATE OF DEATH <i>Nov 29, 1950</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>md</i> B. COUNTY <i>6-03</i>	
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>Snai Hospital</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore</i>	
c. Length of stay in Baltimore Yrs. _____ Mos. _____ Days _____		D. STREET ADDRESS (If rural, give location) <i>226 N. Kenwood Ave</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>N</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>married</i>	8. DATE OF BIRTH <i>Dec 28 1868</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Salesman Woodruff Industries</i>		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <i>81</i>
13. FATHER'S NAME <i>Samuel A. Tyler</i>		11. BIRTHPLACE (State or foreign country) <i>md.</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
14. MOTHER'S MAIDEN NAME <i>Cassandra Gorte</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i> <i>none</i>	
16. SOCIAL SECURITY NO. <i>219-01-3601</i>		17. INFORMANT ADDRESS <i>Enston P. Tyler</i>	
18. <i>422.1</i> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) <i>Multiple pulmonary embolism</i> DUE TO (B) <i>Pneumonia</i> DUE TO (C) <i>myocardial infarction</i> II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Semility - arteriosclerosis</i> INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION <i>11/17</i>		19B. MAJOR FINDINGS OF OPERATION <i>Peripheral Vascular Disease</i>	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>Nov 17, 1950</i> to <i>Nov 29, 1950</i> that I last saw the deceased alive on <i>Nov 29, 1950</i> and that death occurred at <i>8:15 p.m.</i> from the causes and on the date stated above.			
23A. SIGNATURE <i>Allen R. Maltby M.D.</i>		23B. ADDRESS <i>Simon Ross</i>	
23C. DATE SIGNED <i>11/30/50</i>			
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>12-2-50</i>	
24C. NAME OF CEMETERY OR CREMATORY <i>Parkwood</i>		24D. LOCATION (City, town, or county) (State) <i>Taylor Ave</i>	
DATE RECEIVED BY LOCAL REGISTRAR <i>DEC 1 - 1950</i>		REGISTRAR'S SIGNATURE <i>Theravington Williams, M.D.</i>	
25. FUNERAL DIRECTOR <i>Michael T. Blight</i>		ADDRESS <i>6009 Harford Rd</i>	

MEDICAL CERTIFICATION



452

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10264

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Naomi

WILLIAMS

2. DATE
OF
DEATH

Nov. 28, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF
HOSPITAL OR
INSTITUTION

Provident Hospital

Yrs.
Mos.
Days4. USUAL RESIDENCE (Where deceased lived. If institution: residence
A. STATE B. COUNTY before admission)

Maryland

C. CITY OR TOWN (If outside corporate limits with RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

922 Jordan St.

c. Length of stay in Baltimore

5. SEX 6. COLOR OR RACE 7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

F.

Col.

Single

8. DATE OF BIRTH

?-?-1949

9. AGE (In years
last birthday)

1

If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Infant

10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Lee Prison

14. MOTHER'S MAIDEN NAME

Ida Mae Hawkins

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, or unknown) (If yes, give war or dates of service)

no

no

16. SOCIAL
SECURITY NO.

none

17. INFORMANT

Ida Mae Williams Jordan

ADDRESS

18. 492x CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) Pneumonia (Virus)

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.INTERVAL BETWEEN
ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy thereon and from
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,
and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐.

23A. SIGNATURE

William V. Smith

23B. CHIEF MEDICAL EXAMINER.....☐ASSISTANT MEDICAL EXAMINER.....☒M.D. MEDICAL INVESTIGATOR.....☐

23C. DATE SIGNED

Nov. 29, 1950

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

12-4-50

24C. NAME OF CEMETERY OR CREMATORY

Mt. Auburn

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

DEC 1 - 1950

REGISTRAR'S SIGNATURE

William V. Smith

25. FUNERAL DIRECTOR

A. Holstead - 918 - ✓

ADDRESS

Levin Hill ave - 109a

10801-08

UNITED STATES DEPARTMENT OF AGRICULTURE

OFFICE OF THE SECRETARY

10801

REPORT OF THE

COMMISSIONER OF THE GENERAL LAND OFFICE

TO THE SECRETARY OF AGRICULTURE

FOR THE YEAR 1901

AND FOR THE YEAR 1902

AND FOR THE YEAR 1903

AND FOR THE YEAR 1904

AND FOR THE YEAR 1905

AND FOR THE YEAR 1906

AND FOR THE YEAR 1907

AND FOR THE YEAR 1908

AND FOR THE YEAR 1909

AND FOR THE YEAR 1910

AND FOR THE YEAR 1911

AND FOR THE YEAR 1912

AND FOR THE YEAR 1913

AND FOR THE YEAR 1914

AND FOR THE YEAR 1915

AND FOR THE YEAR 1916

AND FOR THE YEAR 1917

AND FOR THE YEAR 1918

AND FOR THE YEAR 1919

AND FOR THE YEAR 1920

AND FOR THE YEAR 1921

AND FOR THE YEAR 1922

AND FOR THE YEAR 1923

AND FOR THE YEAR 1924

AND FOR THE YEAR 1925

**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

50-10265
Registered No.

512
50-10265
BIRTH NO.

1. NAME OF DECEASED (Type or Print) THOMAS SAMPSON			2. DATE OF DEATH November 29, 1950		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 17-02		
B. FULL NAME OF HOSPITAL OR INSTITUTION 1133 Etting Street			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore		
C. Length of stay in Baltimore Life Yrs. Mos. Days			D. STREET ADDRESS (If rural, give location) 1133 Etting Street		
5. SEX Male	6. COLOR OR RACE Colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH 7-7-1910	9. AGE (In years last birthday) 40	10 Under 1 Year Months Days 11 Under 24 Hours Hours Min.
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Capek Banga			11. BIRTHPLACE (State or foreign country) Md.		
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Henry Sampson		
14. MOTHER'S MAIDEN NAME Edna St.			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		
16. SOCIAL SECURITY NO.			17. INFORMANT Henry Sampson - 1133 Etting St.		

18. 590X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Acute glomerulonephritis (A) DUE TO		INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES (B) DUE TO		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (C) DUE TO		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME (Month) (Day) (Year) (Hour) INJURY	21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		

22. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE Stanley K. Omlacher M.D.		23B. CHIEF MEDICAL EXAMINER..... <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER..... <input checked="" type="checkbox"/> MEDICAL INVESTIGATOR..... <input type="checkbox"/>	23C. DATE SIGNED Nov. 30, 1950
24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE 12-2-50	24C. NAME OF CEMETERY OR CREMATORY mt. Auburn	24D. LOCATION (City, town, or county) (State) 130
DATE RECEIVED BY LOCAL REGISTRAR DEC 1 - 1950	REGISTRAR'S SIGNATURE David Hall	25. FUNERAL DIRECTOR W. Halstead - 718 f David Hall	

68-1-1

STATE OF NEW YORK

IN SENATE

January 10, 1910

68-1-1

REPORT OF THE COMMISSIONER OF THE LAND OFFICE, IN RESPONSE TO A RESOLUTION PASSED BY THE SENATE, MAY 1, 1899, RELATIVE TO THE LANDS BELONGING TO THE STATE.

ALBANY: J.B. LIPPINCOTT & CO., PRINTERS, 1910.

THE LANDS BELONGING TO THE STATE OF NEW YORK. A REPORT OF THE COMMISSIONER OF THE LAND OFFICE, IN RESPONSE TO A RESOLUTION PASSED BY THE SENATE, MAY 1, 1899, RELATIVE TO THE LANDS BELONGING TO THE STATE.

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THE LANDS BELONGING TO THE STATE OF NEW YORK. A REPORT OF THE COMMISSIONER OF THE LAND OFFICE, IN RESPONSE TO A RESOLUTION PASSED BY THE SENATE, MAY 1, 1899, RELATIVE TO THE LANDS BELONGING TO THE STATE.

1. NAME OF DECEASED (Type or Print) WARREN H. SLEE		2. DATE OF DEATH 12/1/50	
3. PLACE OF DEATH: a. Baltimore City, Maryland <input checked="" type="checkbox"/>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE md. B. COUNTY Harford	
b. FULL NAME OF (If not in hospital or institution, give street address or location) Church Home + Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore. Aberdeen	
c. Length of stay in Baltimore Yrs. Mos. Days		d. STREET ADDRESS (If rural, give location) Rural Route no. 1, Aberdeen	
5. SEX Mr.	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 4/2/1886
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		9. AGE (In years last birthday) Months: Days 64	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Harford County	
13. FATHER'S NAME Eric H. Slee		12. CITIZEN OF WHAT COUNTRY?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		14. MOTHER'S MAIDEN NAME Annie L. Martin	
16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Church Home Hospital	
18. 180X CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) metastatic carcinoma			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Hyponerplasia, Rt. side			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 11/25/50 to 12/1/50 , that I last saw the deceased alive on 11/25/50 , 19 50 , and that death occurred at 15:10pm from the causes and on the date stated above.			
23a. SIGNATURE H. Reed Carroll		23b. ADDRESS Church Home Hosp	
23c. DATE SIGNED 12/1/50			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE Dec. 3, 1950	
24c. NAME OF CEMETERY OR CREMATORY Specatia		24d. LOCATION (City, town, or county) (State) Jerryman Harford Md	
DATE RECEIVED BY LOCAL REGISTRAR DEC 1 - 1950		REGISTRAR'S SIGNATURE Thurston Williams	
VS 150		25. FUNERAL DIRECTOR ADDRESS Henry Tarrington Sons & Co	

MEDICAL CERTIFICATION

**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

50-10267
Registered No.

BIRTH NO. 50-24870

1. NAME OF DECEASED (Type or Print) Elaine Kolar		2. DATE OF DEATH 11.30.50	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY	
B. FULL NAME OF (If not in hospital or institution, give street address or location) Doctors Hospital		C. CITY OR TOWNSHIP (If outside corporate limits, write RURAL and give township) Baltimore 2-03	
c. Length of stay in Baltimore Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) 827 S. Bond St.	
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Infant	8. DATE OF BIRTH 10.21.50
9. AGE (In years last birthday)		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	11. BIRTHPLACE (State or foreign country) Baltimore
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME Joseph Kolar	
14. MOTHER'S MAIDEN NAME Jubiana Gibour		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Mr. Joseph Kolar, 827 S. Bond St.	

18. 756.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	CAUSE OF DEATH (A) Intestinal Obstruction DUE TO (B) Pyloric Stenosis DUE TO (C) Peritonitis	INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION 11.18.50 & 11.21.50	19B. MAJOR FINDINGS OF OPERATION Stenosis of pylorus & intestinal obstruction	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

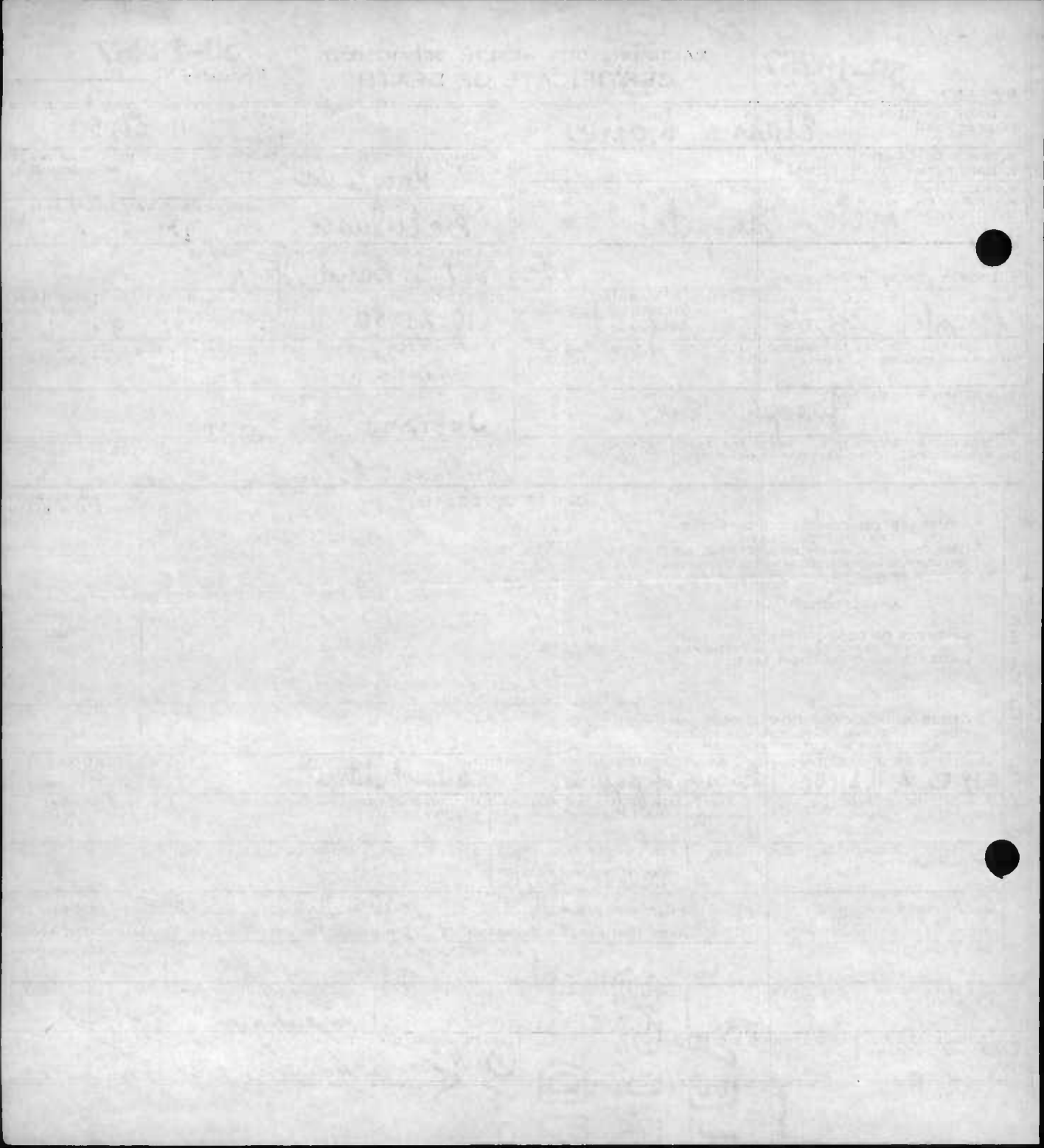
22. I hereby certify that I attended the deceased from **11.15.50**, to **11.30.50**, that I last saw the deceased alive on **11.30.50**, and that death occurred at **4¹⁰ p.m.**, from the causes and on the date stated above.

23A. SIGNATURE Michael J. Saworski	23B. ADDRESS 2711 Eastern Ave.	23C. DATE SIGNED 11/1/50
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial	24B. DATE 11/2/50	24C. NAME OF CEMETERY OR CREMATORY Oak Lawn
24D. LOCATION (City, town, or county) (State) Baltimore Md.	25. FUNERAL DIRECTOR ADDRESS M. J. Saworski, 1808 Eastern Ave.	
DATE RECEIVED BY LOCAL REGISTRAR VS 150		

MEDICAL CERTIFICATION

FC1-1950

1579



625

CARRIGAN

50-10268

50-10268

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) MRS EVA CARRIGAN Eva M. Carrigan		2. DATE OF DEATH 11-30-1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY	
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION CHARLES HOME & HOSPITAL		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE 31 2-02	
c. Length of stay in Baltimore Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) 4115 ANN ST.	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED	8. DATE OF BIRTH APRIL 10 1886
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY RETIRED	9. AGE (In years by birthday) 64
11. BIRTHPLACE (State or foreign country) PENNA. U.S.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME LUKAS ZOWSKI - KIA AUGUST		14. MOTHER'S MAIDEN NAME JOANNA	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.	
17. INFORMANT SON JAMES CARRIGAN		ADDRESS 415 ANN ST BALD 31	

18. 332X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	CAUSE OF DEATH (A) CEREBRAL THROMBOSIS. DUE TO (B) DUE TO (C) DIABETES MELLITUS	INTERVAL BETWEEN ONSET AND DEATH 4 DAYS YEARS
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19A. DATE OF OPERATION 0	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **Nov. 27**, 19**50**, to **Nov 30**, 19**50**, that I last saw the deceased alive on **Nov 29**, 19**50**, and that death occurred at **349** m., from the causes and on the date stated above.

23A. SIGNATURE Ronald J. [Signature]	23B. ADDRESS CHARLES HOME & HOSPITAL	23C. DATE SIGNED Nov 30 1950
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24A. BURIAL, CREMATION, REMOVAL (Specify) Burial	24B. DATE Dec 4-50	24C. NAME OF CEMETERY OR CREMATORY St Stanislaus Cem	24D. LOCATION (City, town, or county) (State) Dundalk Balto Co.
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DATE RECEIVED BY LOCAL REGISTRAR DEC 7-1950	REGISTRAR'S SIGNATURE [Signature]	25. FUNERAL DIRECTOR [Signature]	ADDRESS 1800 E. Lombard St
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1-1958

RECEIVED BY THE DIRECTOR

DEPARTMENT OF DEFENSE

NOV 27

TO: THE DIRECTOR, DEPARTMENT OF DEFENSE

FROM: THE SECRETARY OF DEFENSE

SUBJECT: [Illegible]

REFERENCE: [Illegible]

1. [Illegible]

2. [Illegible]

3. [Illegible]

4. [Illegible]

5. [Illegible]

6. [Illegible]

7. [Illegible]

8. [Illegible]

9. [Illegible]

10. [Illegible]

11. [Illegible]

12. [Illegible]

13. [Illegible]

14. [Illegible]

15. [Illegible]

16. [Illegible]

17. [Illegible]

18. [Illegible]

19. [Illegible]

20. [Illegible]

CERTIFICATE CORRECTED		12-6-50		Macciola	
50-10269		BALTIMORE CITY HEALTH DEPARTMENT		50-10269	
BIRTH NO.		CERTIFICATE OF DEATH		Registered No.	
1. NAME OF DECEASED (Type or Print)		Daniel G. Macciola Jr.		2. DATE OF DEATH Nov. 29-50	
3. PLACE OF DEATH: A. Baltimore City, Maryland		Balto.		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md.	
B. FULL NAME OF HOSPITAL OR INSTITUTION 4902 Ross Rd.		Yrs. Mos. Days		C. CITY OR TOWN (If outside corporate limits, give township) Balto. 27-03	
c. Length of stay in Baltimore 35yrs		D. STREET ADDRESS (If rural, give location) 4902 Ross Rd		5. SEX Male	
6. COLOR OR RACE White		7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH Feb 28 1912	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10B. KIND OF BUSINESS OR INDUSTRY Motor Veh. Comm.		9. AGE (In years last birthday) 39 38	
11. BIRTHPLACE (State or foreign country) Newark New Jersey		12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Daniel Macciola	
14. MOTHER'S MAIDEN NAME Sarah Bruno		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Dorothy A. Macciola		ADDRESS		18. 357 X 1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Syringomyelia Antecedent Causes DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. INTERVAL BETWEEN ONSET AND DEATH 14 yrs	
19A. DATE OF OPERATION 0		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 11-28 to 11-29, 1950, that I last saw the deceased alive on 11-28, 1950, and that death occurred at 11:50 AM, from the causes and on the date stated above.					
23A. SIGNATURE M. L. Suzanne		23B. ADDRESS 11 E. Chase St		23C. DATE SIGNED 11/30/50	
24A. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24B. DATE DEC 2 1950		24C. NAME OF CEMETERY OR CREMATORY NEW CATHARAL CEM	
24D. LOCATION (City, town, or county) MD.		24E. LOCATION (City, town, or county) OLD FREDERICK RD		24F. LOCATION (City, town, or county) MD.	
DATE RECEIVED BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR Duffel Bnd. 7110 BELAIR RD.	

MEDICAL CERTIFICATION

DEC 1 - 1950
VS 150

39092

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BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50-10270

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Ada R. Kettlewell

2. DATE
OF
DEATH

11/29/50

3. PLACE OF DEATH:

a. Baltimore City, Maryland

b. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR INSTITUTION

St Paul Apts - 17+ Royal and St Paul

c. Length of stay in Baltimore

Life

5. SEX

F

6. COLOR OR RACE

W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

SINGLE

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

NONE

10B. KIND OF BUSINESS OR INDUSTRY

13. FATHER'S NAME

Robert C. Kettlewell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

B. COUNTY

c. CITY OR TOWN (If outside corporate limits, write R.R. and give township)

o. STREET ADDRESS (If rural, give location)

St Paul Apts - 17+ Royal and St Paul

8. DATE OF BIRTH

Oct 26 1868

9. AGE (In years last birthday)

82

11 Under 1 Year Months Days

11 Under 24 Hours Hours Min.

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY?

14. MOTHER'S MAIDEN NAME

Josephine B. Cole

17. INFORMANT

ADDRESS

Miss Mary M. Kettlewell St. Paul Apts

18.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A)

DUE TO

Anterior Cerebral Artery Disease

ANTECEDENT CAUSES

(B)

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

[Signature]

M.D.

23B. CHIEF MEDICAL EXAMINER.....
ASSISTANT MEDICAL EXAMINER.....
MEDICAL INVESTIGATOR.....

23C. DATE SIGNED

11/30/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

12-2-50

24C. NAME OF CEMETERY OR CREMATORY

Druid Ridge

24D. LOCATION (City, town, or county)

Pikesville, Md.

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

[Signature]

25. FUNERAL DIRECTOR

ADDRESS

John O. Mitchell Sons 1900 Eutaw Place

CERTIFICATE OF DEATH

1000

1000

2



520
-10271
BIRTH NO.BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50-10271
Registered No.

1. NAME OF DECEASED (Type or Print) JOSEPH ANTHONY THOMAS TANSKI			2. DATE OF DEATH November 29, 1950		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2-03		
B. FULL NAME OF HOSPITAL OR INSTITUTION Johns Hopkins Hospital			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore		
c. Length of stay in Baltimore Yrs. Mos. Days			D. STREET ADDRESS (If rural, give location) 721 S. Broadway		
5. SEX male	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH Jan 8 1900	9. AGE (In years last birthday) 50	10. Under 1 Year Months: Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maritime		10B. KIND OF BUSINESS OR INDUSTRY Seaman	11. BIRTHPLACE (State or foreign country) Balto Md		12. CITIZEN OF WHAT COUNTRY? USA.
13. FATHER'S NAME Unknown			14. MOTHER'S MAIDEN NAME Unknown		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war and date of service) Yes		16. SOCIAL SECURITY NO. 219-16-6315	17. INFORMANT John Vinson		
			ADDRESS 1116 STERRETT ST		

18. 411X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH
(A) Rheumatic heart disease		DUE TO		
ANTECEDENT CAUSES		(B) Aortic stenosis		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		DUE TO		
(C)				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME (Month) (Day) (Year) (Hour) INJURY	21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE <input type="checkbox"/> AT WORK	21F. HOW DID INJURY OCCUR?		

22. I certify that I took charge of the remains described above, held an Inquiry & Inspection thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE William V. Lott		23B. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> MEDICAL INVESTIGATOR <input type="checkbox"/>		23C. DATE SIGNED Nov. 29, 1950
24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE Dec 2	24C. NAME OF CEMETERY OR CREMATORY St. Stanislaus	24D. LOCATION (City, town, or county) (State) Scundack Ave Md	
DATE RECEIVED BY LOCAL REGISTRAR DEC 1 - 1950	REGISTRAR'S SIGNATURE William V. Lott	25. FUNERAL DIRECTOR Charles W. Schuchman		ADDRESS 703 McHenry St.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

DATE OF DEATH

**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

50-10272
Registered No.

651
50-10272
BIRTH NO.

1. NAME OF DECEASED (Type or Print) CARMELO TRIMBOLI			2. DATE OF DEATH November 30, 1950		
3. PLACE OF DEATH: a. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) a. STATE Maryland b. COUNTY Baltimore		
b. FULL NAME OF (If not in hospital or institution, give street address or location) St. Joseph's Hospital			c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore		
c. Length of stay in Baltimore Yrs. Mos. Days			d. STREET ADDRESS (If rural, give location) 2304 Taylor Avenue		
5. SEX male	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH Dec 23-1885		9. AGE (In years last birthday) 64
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer - Crown Cork & Seal			11. BIRTHPLACE (State or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? Italy
13. FATHER'S NAME 2			14. MOTHER'S MAIDEN NAME 2		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
17. INFORMANT Peter Trimboli - 2304 Taylor			ADDRESS		

18. E830.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) Multiple fractures and abrasions			
		DUE TO			
		(B) Ruptured diaphragm			
		(C) Internal hemorrhage			
		DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) industrial place		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Crown Cork & Seal Co. Eastern Ave. & S. Kresson Street	
21D. TIME (Month) (Day) (Year) (Hour) November 30, 1950 12.30 P.M.		21E. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? Pedestrian run over by dump truck 26/7	
22. I certify that I took charge of the remains described above, held an <u>Inquiry & Inspection</u> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input checked="" type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .					
23A. SIGNATURE Stanley K. Duescher M.D.		23B. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> MEDICAL INVESTIGATOR <input type="checkbox"/>		23C. DATE SIGNED Dec. 1, 1950	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/3/50		24C. NAME OF CEMETERY OR CREMATORY Morland Park	
24D. LOCATION (City, town, or county) (State) Baltimore Md		24E. FUNERAL DIRECTOR L. J. Luck		24F. ADDRESS 5305 Harford	
DATE RECEIVED BY LOCAL REGISTRAR DEC 1-1950		REGISTRAR'S SIGNATURE William H. Williams		25. FUNERAL DIRECTOR L. J. Luck	
VS 151		N-829.2		9703Z	
				17000 ✓	

MEDICAL CERTIFICATION

1-1575

MINISTRE DE LA SANTE
CERTIFICATE OF DEATH

1-1575

1. NOM ET COGNOM		2. DATES	
3. SEXE		4. AGE	
5. LIEU DE NAISSANCE		6. LIEU DE DECES	
7. CAUSE DE DECES		8. SIGNATURE DU MEDICIN	
9. SIGNATURE DU DECLARANT		10. REMARQUES	
11. SIGNATURE DU NOTAIRE		12. SIGNATURE DU JUGE	
13. SIGNATURE DU MINISTRE		14. SIGNATURE DU VICE-MINISTRE	
15. SIGNATURE DU SECRETAIRE		16. SIGNATURE DU CHIEF DE BUREAU	
17. SIGNATURE DU CHIEF DE DIVISION		18. SIGNATURE DU CHIEF DE SECTEUR	
19. SIGNATURE DU CHIEF DE REGION		20. SIGNATURE DU CHIEF DE PROVINCE	
21. SIGNATURE DU CHIEF DE PAYS		22. SIGNATURE DU CHIEF DE CANTON	
23. SIGNATURE DU CHIEF DE COMMUNE		24. SIGNATURE DU CHIEF DE LOCALITE	
25. SIGNATURE DU CHIEF DE QUARTIER		26. SIGNATURE DU CHIEF DE RUE	
27. SIGNATURE DU CHIEF DE MAISON		28. SIGNATURE DU CHIEF DE LOGEMENT	
29. SIGNATURE DU CHIEF DE CHAMBRE		30. SIGNATURE DU CHIEF DE COUCHE	
31. SIGNATURE DU CHIEF DE LIT		32. SIGNATURE DU CHIEF DE TABLE	
33. SIGNATURE DU CHIEF DE CHAIR		34. SIGNATURE DU CHIEF DE BOULE	
35. SIGNATURE DU CHIEF DE VERRE		36. SIGNATURE DU CHIEF DE CROUTE	
37. SIGNATURE DU CHIEF DE CROUTE		38. SIGNATURE DU CHIEF DE CROUTE	
39. SIGNATURE DU CHIEF DE CROUTE		40. SIGNATURE DU CHIEF DE CROUTE	
41. SIGNATURE DU CHIEF DE CROUTE		42. SIGNATURE DU CHIEF DE CROUTE	
43. SIGNATURE DU CHIEF DE CROUTE		44. SIGNATURE DU CHIEF DE CROUTE	
45. SIGNATURE DU CHIEF DE CROUTE		46. SIGNATURE DU CHIEF DE CROUTE	
47. SIGNATURE DU CHIEF DE CROUTE		48. SIGNATURE DU CHIEF DE CROUTE	
49. SIGNATURE DU CHIEF DE CROUTE		50. SIGNATURE DU CHIEF DE CROUTE	
51. SIGNATURE DU CHIEF DE CROUTE		52. SIGNATURE DU CHIEF DE CROUTE	
53. SIGNATURE DU CHIEF DE CROUTE		54. SIGNATURE DU CHIEF DE CROUTE	
55. SIGNATURE DU CHIEF DE CROUTE		56. SIGNATURE DU CHIEF DE CROUTE	
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61. SIGNATURE DU CHIEF DE CROUTE		62. SIGNATURE DU CHIEF DE CROUTE	
63. SIGNATURE DU CHIEF DE CROUTE		64. SIGNATURE DU CHIEF DE CROUTE	
65. SIGNATURE DU CHIEF DE CROUTE		66. SIGNATURE DU CHIEF DE CROUTE	
67. SIGNATURE DU CHIEF DE CROUTE		68. SIGNATURE DU CHIEF DE CROUTE	
69. SIGNATURE DU CHIEF DE CROUTE		70. SIGNATURE DU CHIEF DE CROUTE	
71. SIGNATURE DU CHIEF DE CROUTE		72. SIGNATURE DU CHIEF DE CROUTE	
73. SIGNATURE DU CHIEF DE CROUTE		74. SIGNATURE DU CHIEF DE CROUTE	
75. SIGNATURE DU CHIEF DE CROUTE		76. SIGNATURE DU CHIEF DE CROUTE	
77. SIGNATURE DU CHIEF DE CROUTE		78. SIGNATURE DU CHIEF DE CROUTE	
79. SIGNATURE DU CHIEF DE CROUTE		80. SIGNATURE DU CHIEF DE CROUTE	
81. SIGNATURE DU CHIEF DE CROUTE		82. SIGNATURE DU CHIEF DE CROUTE	
83. SIGNATURE DU CHIEF DE CROUTE		84. SIGNATURE DU CHIEF DE CROUTE	
85. SIGNATURE DU CHIEF DE CROUTE		86. SIGNATURE DU CHIEF DE CROUTE	
87. SIGNATURE DU CHIEF DE CROUTE		88. SIGNATURE DU CHIEF DE CROUTE	
89. SIGNATURE DU CHIEF DE CROUTE		90. SIGNATURE DU CHIEF DE CROUTE	
91. SIGNATURE DU CHIEF DE CROUTE		92. SIGNATURE DU CHIEF DE CROUTE	
93. SIGNATURE DU CHIEF DE CROUTE		94. SIGNATURE DU CHIEF DE CROUTE	
95. SIGNATURE DU CHIEF DE CROUTE		96. SIGNATURE DU CHIEF DE CROUTE	
97. SIGNATURE DU CHIEF DE CROUTE		98. SIGNATURE DU CHIEF DE CROUTE	
99. SIGNATURE DU CHIEF DE CROUTE		100. SIGNATURE DU CHIEF DE CROUTE	

236
50-10273
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10273
Registered No.

1. NAME OF DECEASED (Type or Print) FERDINAND J. F. RICHTER			2. DATE OF DEATH November 29, 1950		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived, if institution? residence before admission) A. STATE Maryland B. COUNTY 4-02		
B. FULL NAME OF HOSPITAL OR INSTITUTION University Hospital			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore		
c. Length of stay in Baltimore			D. STREET ADDRESS (If rural, give location) 515 W. Lexington Street		
5. SEX male	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH 7/11/1893	9. AGE (In years last birthday) 57	10. Under 1 Year Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) merchant			11. BIRTHPLACE (State or foreign country) Wilmington N. C.		
10B. KIND OF BUSINESS OR INDUSTRY Restaurant			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Ferdinand J. F. Richter			14. MOTHER'S MAIDEN NAME Anna S. Julia		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) World War I			16. SOCIAL SECURITY NO. -		
17. INFORMANT Henry A. Richter			18. ADDRESS 3501 Eapayne Ave Norfolk Va.		

18. 422.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease		INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) _____ (C) _____		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Inquiry & Inspection thereon and from Autopsy, Inspection or Inquiry the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE Stanley K. Durlacher M.D.		23B. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> MEDICAL INVESTIGATOR <input type="checkbox"/>		23C. DATE SIGNED Nov. 30, 1950
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial	24B. DATE 12/4/50	24C. NAME OF CEMETERY OR CREMATORY New Baltimore Natl	24D. LOCATION (City, town, or county) (State) 5501 Frederick Ave	
DATE RECEIVED BY LOCAL REGISTRAR DEC 1 - 1950		REGISTRAR'S SIGNATURE William H. Williams		25. FUNERAL DIRECTOR John J. Cowan ADDRESS 937 St.

253
50-10274

HONORA M. Nugent
BALTIMORE CITY HEALTH DEPARTMENT

50-10274

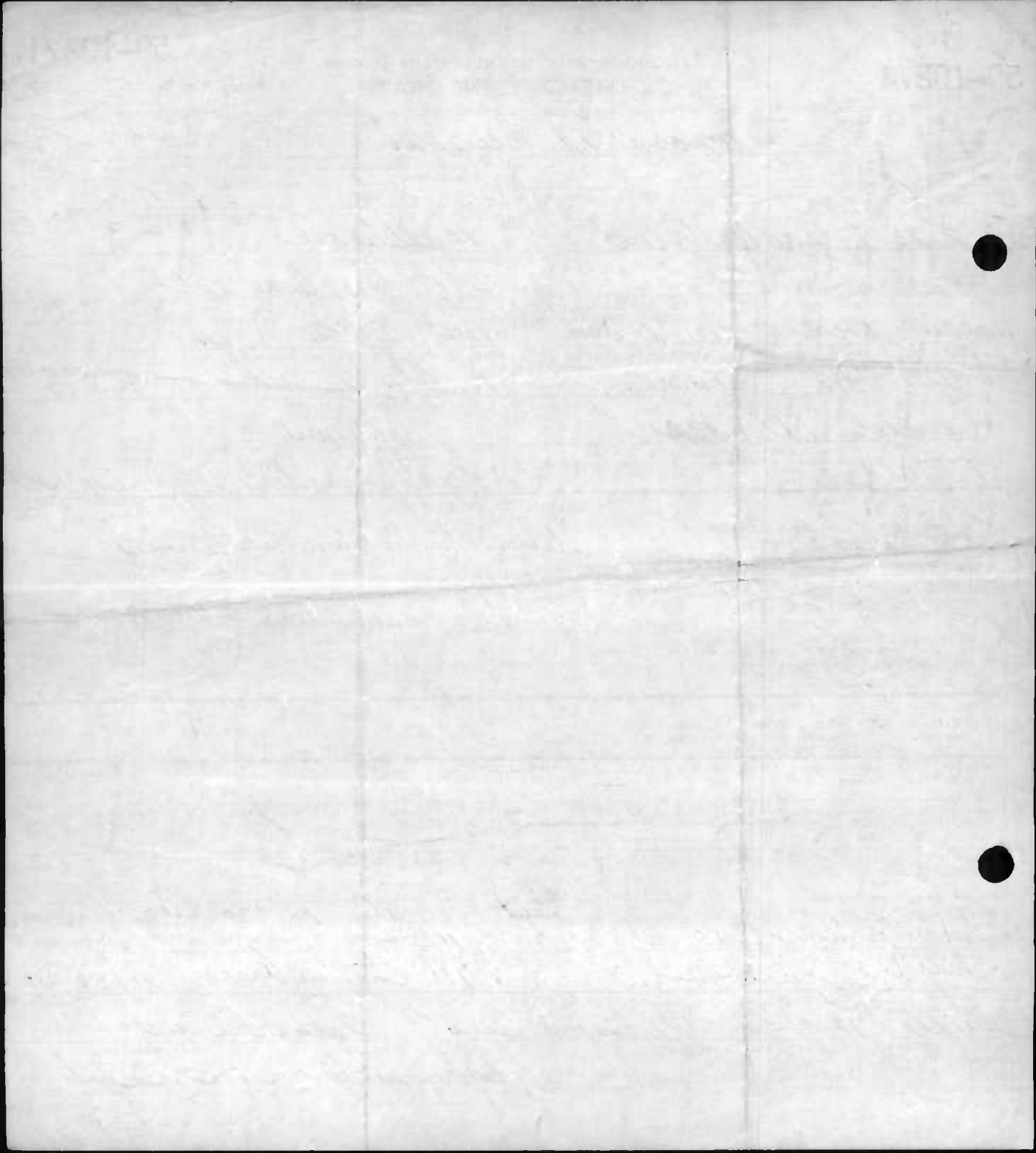
CERTIFICATE OF DEATH

Registered No. _____

1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH	
Honora M. Nugent		11/30/50	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
B. FULL NAME OF (If not in hospital or institution, give street address or location)		A. STATE Md.	
2817 Eastern Ave		B. COUNTY	
C. Length of stay in Baltimore Life		C. CITY OR TOWN (If outside corporate limits, write (L) and give township)	
D. STREET ADDRESS (If rural, give location)		Baltimore 1-02	
E. Yrs. Mos. Days		2817 Eastern Ave	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH
Female	White	Widowed	March 12, 1862
9. AGE (In years last birthday)	10. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday)
88 yrs	house work	at home	88 yrs
11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?		11 Under 1 Year Months: Days
Baltimore, Md.	USA		11 Under 24 Hours Hours: Min.
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)
Samuel Windes	Makron.		(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.	17. INFORMANT		18. ADDRESS
	Mrs Frank Landick		2817 Eastern Ave
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION	
0			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Sept 1950, to Nov 30, 1950, that I last saw the deceased alive on Nov 29, 1950, and that death occurred at 10:15 m., from the causes and on the date stated above.		23A. SIGNATURE	
23B. ADDRESS		23C. DATE SIGNED	
2311 Carter Ave.		11/30/50	
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE	
Burial		12/4/50	
24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)	
Parkwood Cem		Parkville Md	
DATE RECEIVED BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE	
DEC 1 - 1950		Huntington Williams	
25. FUNERAL DIRECTOR		ADDRESS	
Grafton & Son		901 Bellvue St.	

MEDICAL CERTIFICATION

1B. 4221 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
CAUSE OF DEATH
(A) Chronic Cardio Vascular Disease
DUE TO
ANTECEDENT CAUSES
(B) Cardiac Failure.
DUE TO
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(C)
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.



632

50-10275

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10275

Registered No.

1. NAME OF DECEASED
(Type or Print)

Joseph Emory Curtis

2. DATE
OF
DEATH

November 30, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF
HOSPITAL OR
INSTITUTION (If not in hospital or institution, give street address or location)

210 E. Biddle Street

C. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

male

6. COLOR OR RACE

white

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

widowed

8. DATE OF BIRTH

Feb. 19, 1863

9. AGE (in years
last birthday)

87

11 Under 1 Year
Months: Days11 Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Ret. Carpenter

10B. KIND OF BUSINESS OR
INDUSTRY

Washington Navy Yards

11. BIRTHPLACE (State or foreign country)

Savage, Maryland

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Joseph Curtis

14. MOTHER'S MAIDEN NAME

Anne Elizabeth Hilton

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mr. Frank C. Curtis, 3321 Mondawmin Avenue

1B. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) *Arterio-sclerotic Cardiac Vascular
Renal Disease*
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B)
(C)
(D)
(E)
(F)
(G)
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(W)
(X)
(Y)
(Z)II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.INTERVAL BETWEEN
ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11/29, 1950, to 11/30, 1950, that I last saw the
deceased alive on 11/19 and that death occurred at 11:30 p.m., from the causes and on the date stated above.

23A. SIGNATURE

Joseph S. Blum

M. O.

23B. ADDRESS

1115 d. Calvert St.

23C. DATE SIGNED

11/1/50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

burial

24B. DATE

12/4/50

24C. NAME OF CEMETERY OR CREMATORY

Woodlawn Cemetery

24D. LOCATION (City, town, or county)

Woodlawn,

Maryland

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

DEC 1 - 1950

REGISTRAR'S SIGNATURE

William H. Williams

25. FUNERAL DIRECTOR

Wm. Cook, Inc.

ADDRESS

1217 St. Paul Street

61-111-01

61-111-01

3235

61-111-01



520
50-10276

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

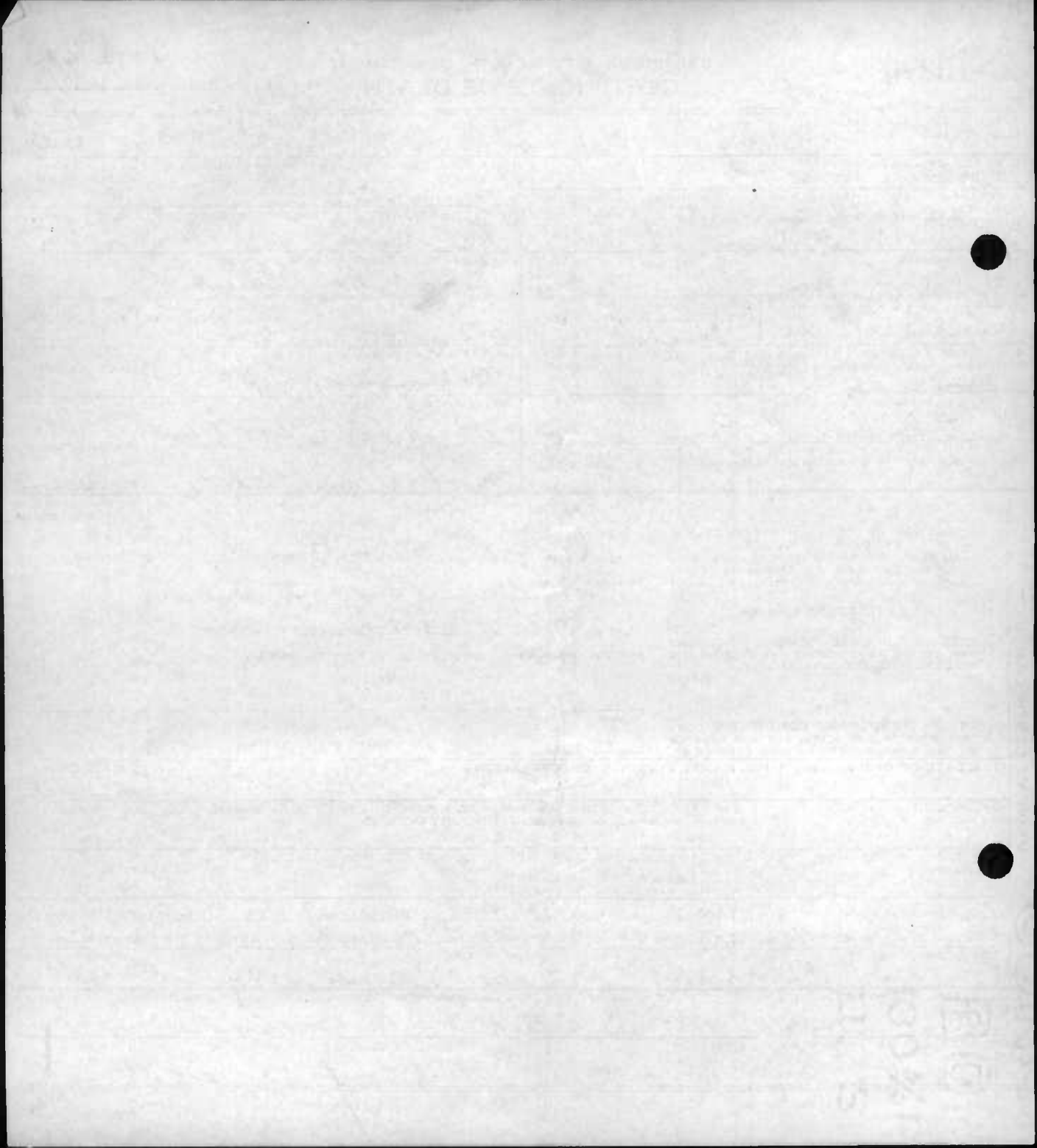
50-10276

Registered No. _____

1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH	
LUCY KING		29 Nov 50	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland	
B. FULL NAME OF HOSPITAL OR INSTITUTION Good Samaritan Hosp 27 N. Carey St		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore	
C. Length of stay in Baltimore Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) 2130 Aiken Street	
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH Dec. 8, 1877
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (in years last birthday) 72
13. FATHER'S NAME Charles L. King		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		12. CITIZEN OF WHAT COUNTRY?	
16. SOCIAL SECURITY NO.		14. MOTHER'S MAIDEN NAME Winifred Cloonan	
17. INFORMANT Mrs. Catherine Flaherty		ADDRESS 2130 Aiken St	

18. 443X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	CAUSE OF DEATH	INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES	(A) Cerebral thrombosis	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO Hypertensive and arteriosclerotic Cardio-vascular disease	
	DUE TO mitral chronic myocarditis	
	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION 0		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 13 Nov, 1950, to 29 Nov, 1950, that I last saw the deceased alive on 28 Nov, 1950, and that death occurred at 5:12 p.m., from the causes and on the date stated above.					
23A. SIGNATURE Emil H. Henning Jr.		23B. ADDRESS 601 Williams Way		23C. DATE SIGNED 1 Dec 50	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/4/50		24C. NAME OF CEMETERY OR CREMATOR New Cathedral	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.		24E. FUNERAL DIRECTOR Wm. Cook, Inc.		24F. ADDRESS 1217 St. Paul St	
DATE RECEIVED BY LOCAL REGISTRAR DEC 1 - 1950		REGISTRAR'S SIGNATURE [Signature]		25. FUNERAL DIRECTOR ADDRESS	



530
50-10277
BIRTH NO.BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHDEC 5 1950
50-10277
Registered No.

1. NAME OF DECEASED (Type or Print) Anna M. Smith		2. DATE OF DEATH 12-1-50	
3. PLACE OF DEATH: A. Baltimore City, Maryland Baltimore		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION 114 N. Clinton St.		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore	
C. Length of stay in Baltimore life		D. STREET ADDRESS (If rural, give location) 114 N. Clinton St.	
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH 6-12-1878
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (in years last birthday) 72 2/3
13. FATHER'S NAME Joseph Pachta		11. BIRTHPLACE (State or foreign country) Maryland	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no		16. SOCIAL SECURITY NO. -	
17. INFORMANT Mrs. Marie Munk		ADDRESS 114 N. Clinton St.	
18. 443X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH	
DUE TO (A) acute congestive heart failure		INTERVAL BETWEEN ONSET AND DEATH 1 hr.	
DUE TO (B) hypertensive cardiac vascular disease		10 yr.	
DUE TO (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION 0		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE <input type="checkbox"/> AT WORK	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Nov 30, 1950, to Dec 1, 1950, that I last saw the deceased alive on Dec 1, 1950, and that death occurred at 1:10 p. m., from the causes and on the date stated above.			
23A. SIGNATURE Burton V. Lock MD.		23B. ADDRESS 2936 E. Balto St	
23C. DATE SIGNED 12/1/50			
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-5-1950	
24C. NAME OF CEMETERY OR CREMATORY Holy Redeemer		24D. LOCATION (City, town, or county) (State) Baltimore Md.	
25. FUNERAL DIRECTOR John A. Moran		ADDRESS 3000 E. Baltimore St.	

50-1077

RECEIVED BY THE DIRECTOR OF THE FBI
JAN 10 1964



**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

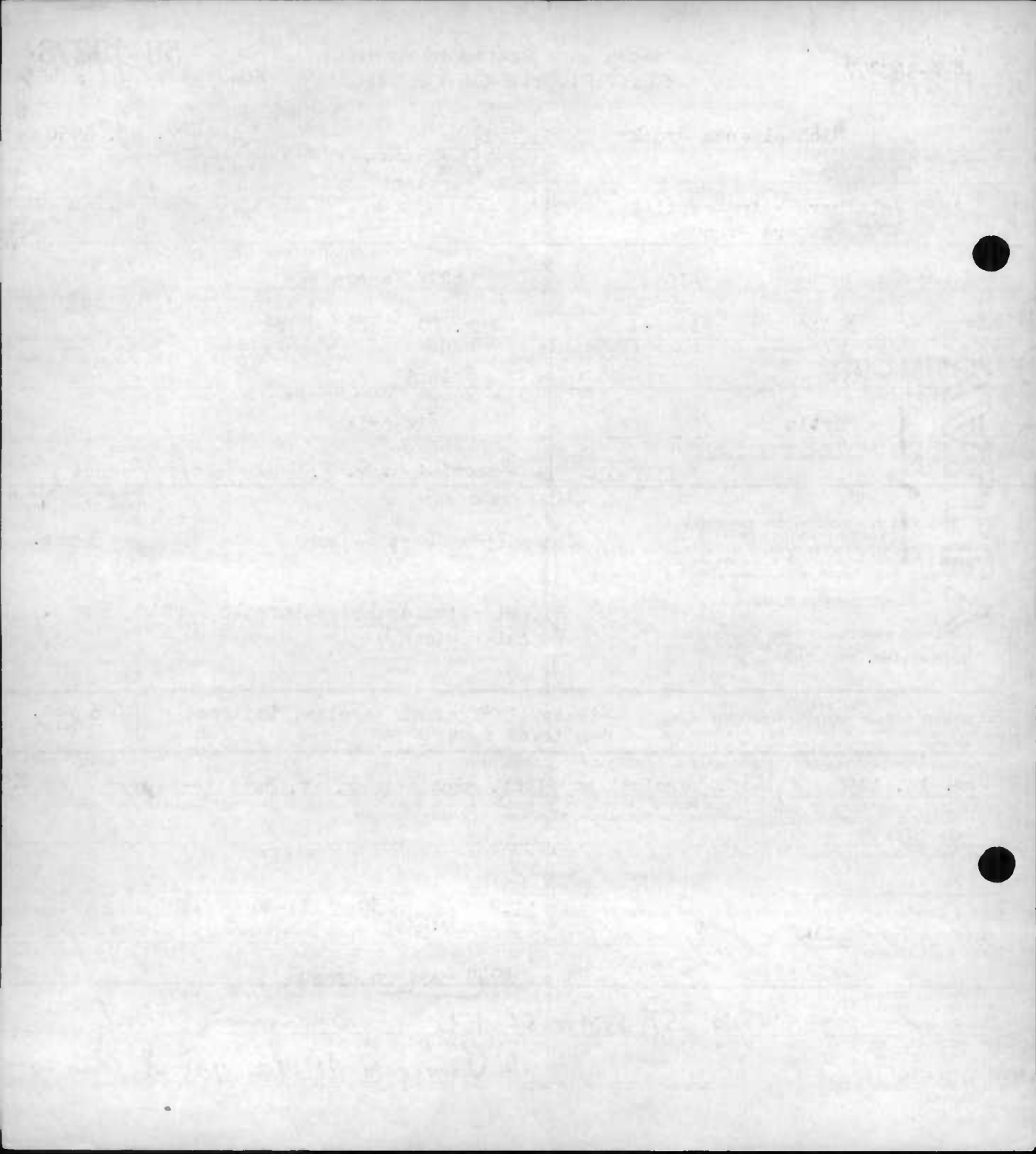
50-10278

Registered No.

620
-242
REA-143207
50-10278

1. NAME OF DECEASED (Type or Print) Michael John Brooks (Cegielski)		2. DATE OF DEATH Nov. 30, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY X	
B. FULL NAME OF HOSPITAL OR INSTITUTION Baltimore City Hospitals 4940 Eastern Avenue		C. CITY OR TOWN (If outside corporate limits, give RURAL and give township) Baltimore	
c. Length of stay in Baltimore Life		D. STREET ADDRESS (If rural, give location) 6222 Ferore Way	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Aug. 20, 1876
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		9. AGE (In years last birthday) 74	
10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Poland	
13. FATHER'S NAME Martin		12. CITIZEN OF WHAT COUNTRY?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		14. MOTHER'S MAIDEN NAME Victoria	
16. SOCIAL SECURITY NO. 217-01-0139		17. INFORMANT ADDRESS Records: B. C. H. 4940 Eastern Avenue	
18. 443 X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Congestive Heart Failure		INTERVAL BETWEEN ONSET AND DEATH 3 yrs.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Hypertensive Arteriosclerotic Cardio Vascular Disease		5 yrs.	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Bilateral Inguinal Herniae, indirect Repair of same		5 yrs. 3 weeks	
19A. DATE OF OPERATION Nov. 12, 1950	19B. MAJOR FINDINGS OF OPERATION Left hernioplasty, lft. orchiectomy, rt. herniorrhaphy		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 11-8 , 19 50 to 11-30 , 19 50 , that I last saw the deceased alive on 11-30 , 19 50 and that death occurred at 9:45A m., from the causes and on the date stated above.			
23A. SIGNATURE <i>[Signature]</i>		23B. ADDRESS 4940 Eastern Avenue	23C. DATE SIGNED
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial	24B. DATE Dec 4-1950	24C. NAME OF CEMETERY OR CREMATORY ST. STANISLAUS	24D. LOCATION (City, town, or county) (State) Baltimore Md.
DATE RECEIVED BY LOCAL REGISTRAR DEC 1 - 1950	REGISTRAR'S SIGNATURE <i>[Signature]</i>	25. FUNERAL DIRECTOR ADDRESS George A. Weber 705 S. ...	

MEDICAL CERTIFICATION



**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

50-10279

Registered No. _____

1. NAME OF DECEASED (Type or Print) William Milliner		2. DATE OF DEATH Nov. 30, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY _____	
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Avenue		C. CITY OR TOWN (If outside corporate limits, state RURAL and give township) Baltimore	
C. Length of stay in Baltimore Life		D. STREET ADDRESS (If rural, give location) 1130 Brewer St.	
5. SEX M	6. COLOR OR RACE N	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Separated	8. DATE OF BIRTH Aug. 10, 1925
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TRUCK DRIVER		10B. KIND OF BUSINESS OR INDUSTRY UNKNOWN	9. AGE (In years last birthday) 25
13. FATHER'S NAME Richard Milliner		11. BIRTHPLACE (State or foreign country) Maryland	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		12. CITIZEN OF WHAT COUNTRY?	
16. SOCIAL SECURITY NO.		14. MOTHER'S MAIDEN NAME Ada Gordon	
17. INFORMANT Baltimore City Hospitals Records: 4940 Eastern Avenue			

18. 583X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Hepatitis - type unknown DUE TO INTERVAL BETWEEN ONSET AND DEATH 15 months	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (B) DUE TO (C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Meningitis - type unknown INTERVAL BETWEEN ONSET AND DEATH 1 Week	

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW OLD INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 11-27 , 19 50 , to 11-30 , 19 50 , that I last saw the deceased alive on 11-30 , 19 50 , and that death occurred at 1:10 p. m. , from the causes and on the date stated above.					
23A. SIGNATURE <i>[Signature]</i>		23B. ADDRESS 4940 Eastern Avenue		23C. DATE SIGNED 12-1-50	
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
Burial		12/4/50		Mt. Auburn	
24D. LOCATION (City, town, or county) (State)		24E. LOCATION (City, town, or county) (State)			
Baltimore		Baltimore			
DATE RECEIVED BY LOCAL REGISTRAR DEC 1 - 1950		REGISTRAR'S SIGNATURE <i>[Signature]</i>		25. FUNERAL DIRECTOR <i>[Signature]</i>	

001-50

001-50



263

Bookhart

50-10280

50-10280

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. _____

1. NAME OF DECEASED (Type or Print) Elder, John Anderson Bookhart			2. DATE OF DEATH II/30/1950		
3. PLACE OF DEATH: A. Baltimore City, Maryland Balto. City			4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE Maryland B. COUNTY _____		
B. FULL NAME OF HOSPITAL OR INSTITUTION 416 N. Fremont Avenue			C. CITY OR TOWN (If outside corporate limits, write FULL and give township) Baltimore City		
c. Length of stay in Baltimore 3 weeks			D. STREET ADDRESS (If rural, give location) 416 N. Fremont Avenue		
5. SEX Male	6. COLOR OR RACE Col.	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 6/10/1870		9. AGE (in years last birthday) 80
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Minister		10B. KIND OF BUSINESS OR INDUSTRY Minister	11. BIRTHPLACE (State or foreign country) Fairfield Co.S.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Daniel Bookhart			14. MOTHER'S MAIDEN NAME Viola Durham		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS Daniel Bookhart 1245 E. Lexington		

18. 420.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Myocardial Infarction		CAUSE OF DEATH	INTERVAL BETWEEN ONSET AND DEATH 3-4 hrs.
DUE TO		(A)	
DUE TO		(B) Coronary Heart Disease	Undet
DUE TO		(C) Hypertensive cardiovascular renal disease.	Undet
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			

19A. DATE OF OPERATION 0		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Nov. 2, 1950 , to Nov 30, 1950 , that I last saw the deceased alive on Nov 29, 1950 , and that death occurred at 7:20 a.m. , from the causes and on the date stated above.					
23A. SIGNATURE H. Garland Russell		23B. ADDRESS 902 W. Franklin		23C. DATE SIGNED 12-1-50	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/6/1950		24C. NAME OF CEMETERY OR CREMATORY Gurgu Cem.	
24D. LOCATION (City, town, or county) Gencoe Florida		24E. (State) Florida		25. FUNERAL DIRECTOR ADDRESS Elroy O. Wilson 1000 Brantley Ave	

VS 150

DEC 2 - 1950

MEDICAL CERTIFICATION

00-1-03

400
50-10281BELL
BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50-10281
Registered No.

1. NAME OF DECEASED (Type or Print) <u>Bell, Joseph Harry</u>			2. DATE OF DEATH <u>Nov. 30, 1950</u>			
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>			
B. FULL NAME OF HOSPITAL OR PHYSICIAN <u>St. Joseph's</u>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <u>Baltimore</u>			
c. Length of stay in Baltimore Yrs. <u>0</u> Mos. <u>0</u> Days <u>0</u>			D. STREET ADDRESS (If rural, give location) <u>1705 Byrd St.</u>			
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>MARCH 8, 1878</u>	9. AGE (In years last birthday) <u>72</u>	If Under 1 Year Months: <u>0</u> Days: <u>0</u>	If Under 24 Hours Hours: <u>0</u> Min. <u>0</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unemployed TRUCK DRIVER</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>NEWSPAPER</u>			
11. BIRTHPLACE (State or foreign country) <u>BALTIMORE, MD.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>THATCHER BELL</u>			14. MOTHER'S MAIDEN NAME <u>JANE CHILCOAT</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>—</u>			16. SOCIAL SECURITY NO. <u>—</u>			
17. INFORMANT <u>MR. CHARLES T. BELL</u>			ADDRESS <u>1705 BYRD ST</u>			

18. <u>561.0</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>Perforation of the bowel</u> DUE TO <u>Gangrene</u> DUE TO <u>Strangulated inguinal hernia</u>			CAUSE OF DEATH <u>Perforation of the bowel</u> <u>Gangrene</u> <u>Strangulated inguinal hernia</u>			INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION <u>Nov. 17 & 25, 1950</u>			19B. MAJOR FINDINGS OF OPERATION <u>Inguinal hernia, left; Appendicitis, acute</u>			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) <u>—</u>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>—</u>			21C. WHERE DID INJURY OCCUR? <u>—</u>		
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>—</u>			21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21F. HOW DID INJURY OCCUR? <u>—</u>		
22. I hereby certify that I attended the deceased from <u>November 13, 1950</u> to <u>November 30, 1950</u> , that I last saw the deceased alive on <u>Nov. 30, 1950</u> , and that death occurred at <u>6:45 a.m.</u> , from the causes and on the date stated above.								
23A. SIGNATURE <u>B. J. J. J.</u>			23B. ADDRESS <u>1100 N. Caroline St.</u>			23C. DATE SIGNED <u>November 30/50</u>		
24A. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>			24B. DATE <u>12/4/50</u>			24C. NAME OF CEMETERY OR CREMATORY <u>PARKWOOD</u>		
24D. LOCATION (City, town, or county) (State) <u>TAYLOR AVE</u>			24E. DATE RECEIVED BY LOCAL REGISTRAR <u>DEC 2-1950</u>			24F. REGISTRAR'S SIGNATURE <u>W. J. J. J.</u>		
24G. FUNERAL DIRECTOR <u>JOHN F. DENNY, INC</u>			24H. ADDRESS <u>715 LIGHT ST -30</u>			24I. VS 150 <u>6834M</u>		

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CERTIFICATE OF DEATH

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**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

50-10282

Registered No.

200
50-10282

BIRTH NO. 50-25713

1. NAME OF DECEASED (Type or Print) John Wayne Hauck		2. DATE OF DEATH 12-1-50	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE MD B. COUNTY	
B. FULL NAME OF (If not in hospital or institution, give street address or location) Bon SECOURS Hospital		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE	
c. Length of stay in Baltimore Yrs. _____ Mos. _____ Days _____		D. STREET ADDRESS (If rural, give location) 110 WILLARD ST.	
5. SEX MALE	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH 11-28-50
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) BALTIMORE		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME John Valentine Hauck		14. MOTHER'S MAIDEN NAME Mary Catherine Eckstrom	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		ADDRESS	

18. 7620 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	CAUSE OF DEATH (A) BRONCHO PNEUMONIA DUE TO (B) ATELECTASIS DUE TO (C)	INTERVAL BETWEEN ONSET AND DEATH 24 hrs 74 hrs

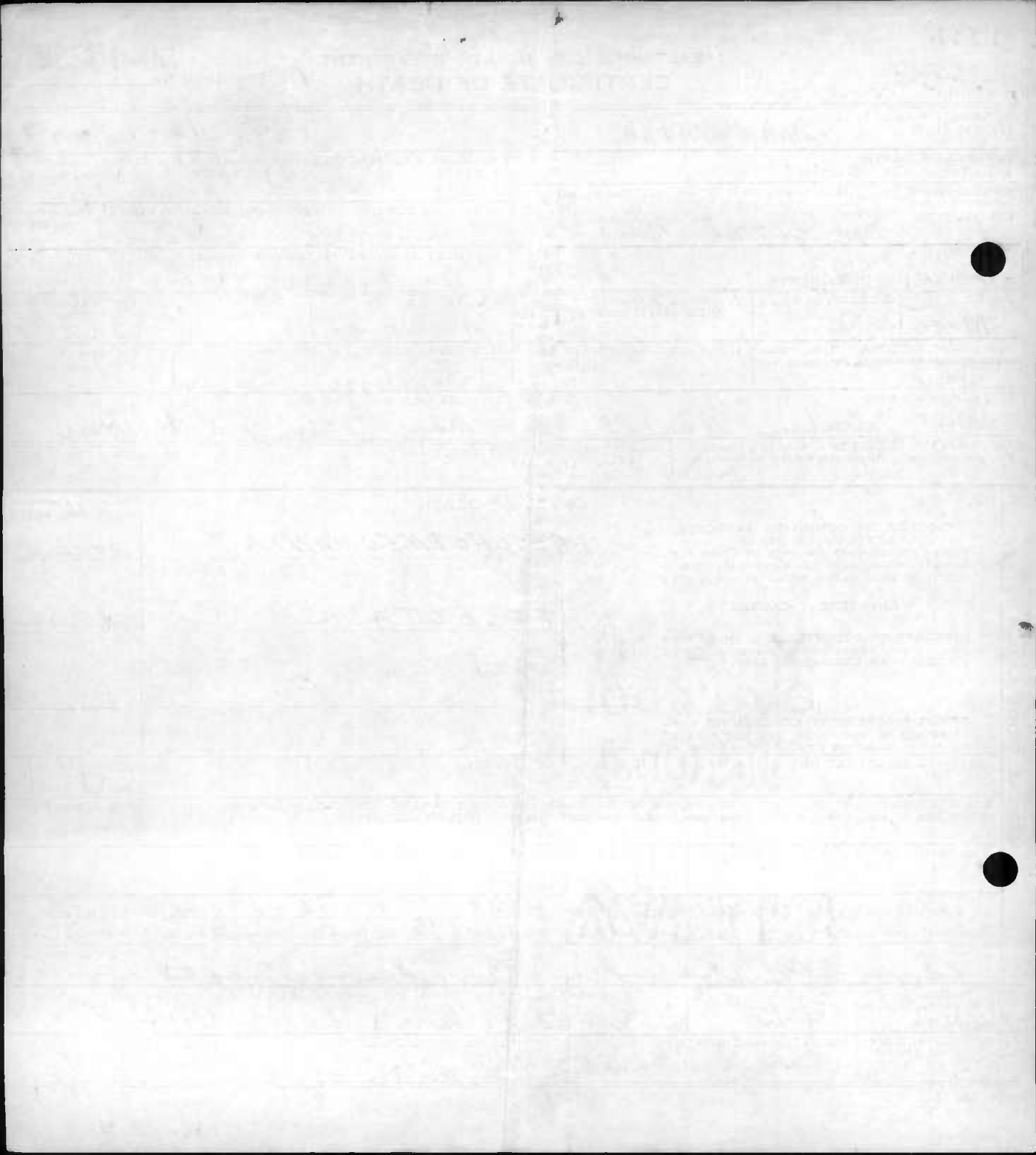
19A. DATE OF OPERATION 0		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from **11-28** 19**50**, to **12-1**, 19**50**, that I last saw the deceased alive on **12-1**, 19**50**, and that death occurred at **1:30** m., from the causes and on the date stated above.

23A. SIGNATURE Edward M. Relake M. D.	23B. ADDRESS Bon Secours Hospital	23C. DATE SIGNED 12-1-50
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24A. BURIAL, CREMATION, REMOVAL (Specify) Burial	24B. DATE 12/2/50	24C. NAME OF CEMETERY OR CREMATORY Landon Plk.	24D. LOCATION (City, town, or county) (State) Balto. Md.
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DATE RECEIVED BY LOCAL REGISTRAR DEC 2 - 1950	REGISTRAR'S SIGNATURE <i>William Williams</i>	25. FUNERAL DIRECTOR 24 Mr. J. Tolens & Sons - Balto	ADDRESS Md.
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512
50-10283

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10283
Registered No.

1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH	
ANNIE EDITH UMBACH		Dec 1, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY	
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION Maryland Gen. Hosp.		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore.	
c. Length of stay in Baltimore Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) 3032 St Paul St	
5. SEX Female	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widow	8. DATE OF BIRTH Jul 3, 1866
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10B. KIND OF BUSINESS OR INDUSTRY --	9. AGE (In years last birthday) 84
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Michael S. Jenkins		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) -- no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mrs. John R. Cupit - 3702 N. Charles St.		ADDRESS Apt. 210	
18. 422.1 and E903.0 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH (A) Arterio Sclerotic disease of the heart with decompensation. (B) St. approved by Medical Examiner. CERTIFICATION APPROVED BY DR. G. J. LUBINSKI DR. William H. ... CHIEF OR ASST. MEDICAL EXAMINER. Int.	
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) Home.	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 3032 St Paul St Baltimore Md		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY 9/20/50	
21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? Slipped & fell on floor	
22. I hereby certify that I attended the deceased from 9/20/50, 1950, to 12/1/50, 1950, that I last saw the deceased alive on 12/1/50, 1950, and that death occurred at 10:43 AM., from the causes and on the date stated above.			
23A. SIGNATURE G. E. ...		23B. ADDRESS M. O. Maryland Gen. Hosp.	
23C. DATE SIGNED 12/1/50			
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/4/50	
24C. NAME OF CEMETERY OR CREMATORY Druid Ridge Cem.		24D. LOCATION (City, town, or county) (State) Pikesville, Md.	
DATE RECEIVED BY LOCAL REGISTRAR DEC 2 - 1950		REGISTRAR'S SIGNATURE Wm. J. ...	
25. FUNERAL DIRECTOR Wm. J. ...		ADDRESS 186a ...	

2501-10

1951

THE STATE OF

IN THE COUNTY OF

BEFORE ME, the undersigned authority, on this day personally appeared

WILLIAM

JOHN

JOHN

JOHN

JOHN

1951

610
10-10284BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50-10284
Registered No.

1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH	
MARY MAE MURPHY		Nov. 30, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md.	
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION 1527 Sheffield Rd.		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore	
c. Length of stay in Baltimore Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) 1527 Sheffield Rd.	
5. SEX female	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) widowed	8. DATE OF BIRTH June 2, 1888
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY at home	9. AGE (In years: last birthday) 62
11. BIRTHPLACE (State or foreign country) New Jersey		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Thomas Harris		14. MOTHER'S MAIDEN NAME Martha Potter	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) -		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Barrett M. Adams - 1527 Sheffield Rd		ADDRESS	
18. 443 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Cerebral Embolism DUE TO HYPERTENSIVE Cardio-Vascular Disease INTERVAL BETWEEN ONSET AND DEATH 2 hrs. 10 yrs.		19A. DATE OF OPERATION 19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I hereby certify that I attended the deceased from Jan 15, 1940 to Nov. 30, 1950 that I last saw the deceased alive on Nov. 30, 1950, and that death occurred at 6 p. m., from the causes and on the date stated above.	
23A. SIGNATURE Elmer H. Hume		23B. ADDRESS 1801 E. Fair Pl.	
23C. DATE SIGNED 12/1/50		24A. BURIAL, CREMATION, REMOVAL (Specify) Burial	
24B. DATE 12/4/50		24C. NAME OF CEMETERY OR CREMATORY Loudon Park	
24D. LOCATION (City, town, or county) (State) Balto., Md.		25. FUNERAL DIRECTOR J. H. Hume	
DATE RECEIVED BY LOCAL REGISTRAR DEC 2 - 1950		ADDRESS 937 md.	

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555
50-10285BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50-10285

BIRTH NO.

1. NAME OF DECEASED (Type or Print) EDITH SUSAN HENNEMAN		2. DATE OF DEATH 12-1-50	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Baltimore	
B. FULL NAME OF HOSPITAL OR INSTITUTION Lutheran Hosp. of Maryland		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore	
c. Length of stay in Baltimore		D. STREET ADDRESS (If rural, give location) 3000 Littleton Rd #16 Littleton	
5. SEX FEMALE	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widow	8. DATE OF BIRTH Nov 30, 1889
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clark		9. AGE (In years last birthday) 61	
10B. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME William G. O'Brien		12. CITIZEN OF WHAT COUNTRY? Maryland	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no		16. SOCIAL SECURITY NO.	
17. INFORMANT Mr. Geo. W. Henneman - 8 S. Rosedale St.		ADDRESS	

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) DUE TO (A) Posterior Myocardial Infarction (B) Hypertensive Cardiovascular Disease (C) Residual of Left Hemiplegia	INTERVAL BETWEEN ONSET AND DEATH 19 hours 7 1 wks.
19A. DATE OF OPERATION 19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12-1-50, 19__, to __, 19__, that I last saw the deceased alive on 12-1-50, 19__, and that death occurred at 3:55 p.m., from the causes and on the date stated above.

23A. SIGNATURE Harold L. Daly Jr.	23B. ADDRESS Luth. Hosp of Maryland	23C. DATE SIGNED 12-1-50
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24A. BURIAL, CREMATION, REMOVAL (Specify) Burial--	24B. DATE 12/4/50	24C. NAME OF CEMETERY OR CREMATORY Loudon Park Cem.	24D. LOCATION (City, town, or county) (State) Balto., Md.
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DATE RECEIVED BY LOCAL REGISTRAR DEC 2 - 1950	REGISTRAR'S SIGNATURE Cuthbert Williams, Jr.	25. FUNERAL DIRECTOR J. M. J. Pickner & Sons - Balto Md	ADDRESS
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IN SENATE

January 1, 1908

REPORT OF THE

COMMISSIONER

OF THE

LAND OFFICE

FOR THE YEAR

1907

ALBANY: J.B. LIPPINCOTT & CO., PRINTERS, 1908.

THE LAND OFFICE OF THE STATE OF NEW YORK

has the honor to acknowledge the receipt of the

REPORT OF THE

COMMISSIONER OF THE LAND OFFICE

FOR THE YEAR

1907, and to express its appreciation of the

care and attention given to the preparation of the

same.

Very respectfully,

THE SENATE

January 1, 1908

632

50-10286

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10286

Registered No.

1. NAME OF DECEASED (Type or Print) LILLIAN SCHWARTZ		2. DATE OF DEATH December 1, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION Johns Hopkins Hospital		C. CITY OR TOWN (If outside corporate limits, write full name and give township) Baltimore	
C. Length of stay in Baltimore <i>Life</i>		D. STREET ADDRESS (If rural, give location) 414 E. Eager Street	
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Widow</i>	8. DATE OF BIRTH <i>June 27/92</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>none</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>none</i>	
13. FATHER'S NAME <i>Wm Stewart</i>		14. MOTHER'S MAIDEN NAME <i>Martha</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>none</i>	
17. INFORMANT <i>Mrs. Myrtle Davis, 414 E. Eager</i>		ADDRESS	

18. <i>443 X</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) HYPERTENSIVE CARDIOVASCULAR DISEASE (A) DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO (C) II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	CAUSE OF DEATH HYPERTENSIVE CARDIOVASCULAR DISEASE (A) DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO (C)	INTERVAL BETWEEN ONSET AND DEATH
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19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	

22. I certify that I took charge of the remains described above, held an Insp. & Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE <i>Stanley N. Dineen</i>		23B. CHIEF MEDICAL EXAMINER..... ASSISTANT MEDICAL EXAMINER..... M.D. MEDICAL INVESTIGATOR.....		23C. DATE SIGNED 12-1-50	
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24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>Dec 2/50</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Baldwin</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore</i>	
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DATE RECEIVED BY LOCAL REGISTRAR DEC 2 - 1950		REGISTRAR'S SIGNATURE <i>William H. Williams</i>		25. FUNERAL DIRECTOR <i>Philip Henry Sons</i>		ADDRESS <i>2024 Orleans St, Baltimore MD</i>	
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50-10287
ND-143529BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10287

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Joseph Morrissey

2. DATE
OF
DEATH

Nov. 26, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street address or location)
Baltimore City Hospitals
4940 Eastern Avenue4. USUAL RESIDENCE (Where deceased lived. If institution: residence
A. STATE B. COUNTY before admission)

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

941 W. Lombard Street (23)

c. Length of stay in Baltimore

Life

Yrs.
Mos.
Days

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

July 4, 1883

9. AGE (in years
last birthday)

67

If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

UNKNOWN

10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

John Morrissey

14. MOTHER'S MAIDEN NAME

Bridget Quinn

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.17. INFORMANT ADDRESS
Records: Baltimore City Hospitals
4940 Eastern Avenue

18. 331X

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) Cerebral Vascular

DUE TO

2 Days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) Hypertension Pulmonary Emphysema

DUE TO

1 Year

(C)

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT WAS UNDER-
LYING OR CONTRIBUTING
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE
WORK AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11-20, 1950, to 11-26, 1950, that I last saw the
deceased alive on 11-26, 1950 and that death occurred at 7:45 a.m., from the causes and on the date stated above.

23A. SIGNATURE

M. D.

23B. ADDRESS

4940 Eastern Avenue

23C. DATE SIGNED

Dec. 1, 1950

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

12/2/50

24C. NAME OF CEMETERY OR CREMATORY

St. Petrus Cem.

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

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UNITED STATES DEPARTMENT OF AGRICULTURE

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50-10238BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10288

Registered No.

1. NAME OF DECEASED (Type or Print) William McGowan		2. DATE OF DEATH November 30, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore	
B. FULL NAME OF HOSPITAL OR INSTITUTION 3001 N. Calvert Street		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore	
c. Length of stay in Baltimore		D. STREET ADDRESS (If rural, give location) 3001 N. Calvert Street	
5. SEX male	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) widowed	8. DATE OF BIRTH March 31, 1860
9. AGE (In years last birthday) 90		11. BIRTHPLACE (State or foreign country) Ohio	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Accountant		10B. KIND OF BUSINESS OR INDUSTRY B. & O. R. R.	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME Andrew McGowan	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Grace M. Lazenby, Temple Court Apts.		ADDRESS	
18. 331X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CENTRAL ACCIDENT		CAUSE OF DEATH (A) CENTRAL ACCIDENT DUE TO (B) ARTERIO SCLEROSIS DUE TO (C) SMOKING none	
19. DATE OF OPERATION none		19B. MAJOR FINDINGS OF OPERATION none	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH none		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) none	
21C. WHERE DID INJURY OCCUR? none		21D. TIME (Month) (Day) (Year) (Hour) none	
21E. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? none	
22. I hereby certify that I attended the deceased from 1900 to 1950, that I last saw the deceased alive on 30th, 1950, and that death occurred at 7:00 p.m., from the causes and on the date stated above.			
23A. SIGNATURE William McGowan		23B. ADDRESS 412 Park Ave.	
23C. DATE SIGNED 10/2/1950			
24A. BURIAL, CREMATION, REMOVAL (Specify) burial		24B. DATE 12/2/50	
24C. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery		24D. LOCATION (City, town, or county) (State) Pikesville, Maryland	
DATE RECEIVED BY LOCAL REGISTRAR DEC 2 - 1950		REGISTRAR'S SIGNATURE William McGowan	
25. FUNERAL DIRECTOR Wm. Cook, Inc.		ADDRESS 1217 St. Paul Street	

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50-10289BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50-10289

1. NAME OF DECEASED (Type or Print) Lillian Linn Shaw			2. DATE OF DEATH November 30, 1950		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY		
B. FULL NAME OF HOSPITAL OR INSTITUTION 1122 Forrest Street			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore		
c. Length of stay in Baltimore Yrs. Mos. Days			D. STREET ADDRESS (If rural, give location) 1122 Forrest Street		
5. SEX female	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) single	B. DATE OF BIRTH March 4, 1882	9. AGE (in years last birthday) 68	11. BIRTHPLACE (State or foreign country) Carroll County, Maryland
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) never employed			12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME William E. Shaw			14. MOTHER'S MAIDEN NAME Ella Linn		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS Wilmer B. Shaw, 3911 Keswick Road		
18. 42011 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) acute coronary thrombosis DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Cardio - Vascular (arterio-sclerotic) Disease DUE TO OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			INTERVAL BETWEEN ONSET AND DEATH 15 minutes ?		
19A. DATE OF OPERATION 0		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 2 Dec., 1950 , to 1 Dec., 1950 that I last saw the deceased alive on 30 Nov., 1950 , and that death occurred at 11:30 a. m. , from the causes and on the date stated above.					
23A. SIGNATURE Samuel Lieberfeld		23B. ADDRESS 714 E. Preston St.		23C. DATE SIGNED 1 Dec 1950	
24A. BURIAL, CREMATION, REMOVAL (Specify) burial		24B. DATE 12/4/50		24C. NAME OF CEMETERY OR CREMATORY Piney Creek Cemetery	
24D. LOCATION (City, town, or county) Carroll County, Md.		24E. DATE RECEIVED BY LOCAL REGISTRAR DEC 2 - 1950		24F. REGISTRAR'S SIGNATURE William E. Shaw	
24G. FUNERAL DIRECTOR Wm. Cook, Inc.		24H. ADDRESS 1217 St. Paul Street		24I. VS 150	

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50-10290

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50-10290

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Charles N. Elliott

2. DATE
OF
DEATH

Nov. 30, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF
HOSPITAL OR
INSTITUTION (If not in hospital or institution, give street address or location)

906 N. Calvert Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE
Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

906 N. Calvert Street

C. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

male

6. COLOR OR RACE

white

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

married

8. DATE OF BIRTH

July 6, 1869

9. AGE (In years
last birthday)

81

If Under 1 Year
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Ret. Shipping Clerk

10B. KIND OF BUSINESS OR
INDUSTRY

Candy business

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Joseph S. Elliott

14. MOTHER'S MAIDEN NAME

Catherine Clayton

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

216-01-8692

17. INFORMANT ADDRESS
Mrs. Mildred Holland, 906 N. Calvert St.

18. 420.1

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)(A)
DUE TO

Coronary Thrombosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B)
DUE TO
(C)

Hypertension + arteriosclerosis

INTERVAL BETWEEN
ONSET AND DEATH

4 days.

Many
years.II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?
YES ☐ NO ☒21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH21B. PLACE OF INJURY (e.g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE
WORK AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Apr. 1, 1950, to Nov. 30, 1950, that I last saw the deceased alive on Nov. 30, 1950, and that death occurred at 4:45 P.M., from the causes and on the date stated above.

23A. SIGNATURE

Louis E. Wice

M. D.

23B. ADDRESS

920 St. Paul St.

23C. DATE SIGNED

Dec. 1, 1950

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

burial

24B. DATE

12/4/50

24C. NAME OF CEMETERY OR CREMATORY

Loudon Park Cemetery

24D. LOCATION (City, town, or county)

Baltimore,

(State)

Maryland

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

L. J. Williams, Jr.

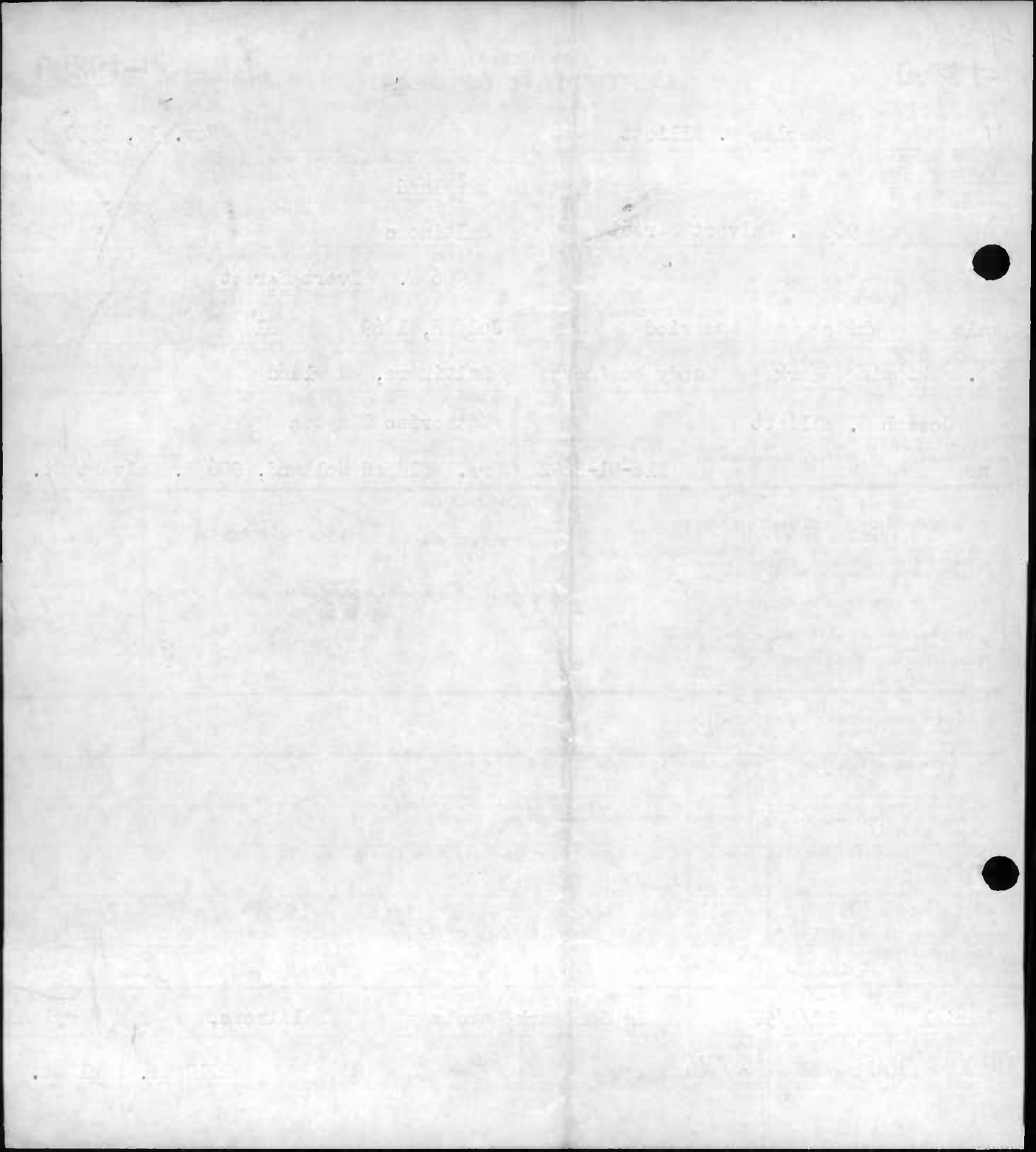
25. FUNERAL DIRECTOR

H. M. Cook, Jr.

ADDRESS

1217 St. Paul St.

94a



530
0-10291

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50-10291

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <i>Lillie J. Smith</i>			2. DATE OF DEATH <i>11-29-1950</i>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY		
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>1518 West Lammale Street</i> <i>20</i> Yrs. Mos. Days			C. CITY OR TOWN (If outside corporate limits, write location and give township) <i>Baltimore</i> <i>16-02</i>		
C. Length of stay in Baltimore			D. STREET ADDRESS (If rural, give location) <i>1518 West Lammale Street</i>		
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Colored</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>married</i>	8. DATE OF BIRTH <i>5-28-1895</i>	9. AGE (In years last birthday) <i>55</i>	10. Under 1 Year Months Days 11. Under 24 Hours Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife</i>			10B. KIND OF BUSINESS OR INDUSTRY		
13. FATHER'S NAME <i>Morgan Tyler</i>			11. BIRTHPLACE (State or foreign country) <i>Richmond Va</i>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, oo or tokooow) <i>No</i>			12. CITIZEN OF WHAT COUNTRY? <i>U.S. A</i>		
16. SOCIAL SECURITY NO. <i>None</i>			14. MOTHER'S MAIDEN NAME <i>Clara</i>		
17. INFORMANT <i>Cornelius W. Smith</i>			ADDRESS <i>1518 W. Lammale St</i>		

1B. <i>443X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	CAUSE OF DEATH (A) <i>Hypertensive Type Heart Disease</i> DUE TO (B) _____ DUE TO (C) _____ INTERVAL BETWEEN ONSET AND DEATH
--	--

19A. DATE OF OPERATION <i>None</i>	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <i>None</i>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>None</i>	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <i>-----</i>
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <i>None</i>	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR? <i>-----</i>

22. I hereby certify that I attended the deceased from *Oct. 12*, 1950 to *Nov. 29*, 1950, that I last saw the deceased alive on *Nov. 29*, 1950, and that death occurred at *3:58 P.m.*, from the causes and on the date stated above.

23A. SIGNATURE <i>Ernest B. Biles</i> M. D.	23B. ADDRESS <i>601 N. Calhoun St.</i>	23C. DATE SIGNED <i>12/1/50</i>
---	---	------------------------------------

24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>12/3/50</i>	24C. NAME OF CEMETERY OR CREMATORY <i>Western Star</i>	24D. LOCATION (City, town, or county) (State) <i>Pattersonville Md</i>
DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE <i>Ernest B. Biles</i>	25. FUNERAL DIRECTOR <i>Joseph A. Lively</i>	ADDRESS <i>661 W. Barre</i>

DEC 2 1950
VS 150

937-27

1500

100

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620
50-10292BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50-10292
Registered No.

1. NAME OF DECEASED (Type or Print) MARY M. DORSEY		2. DATE OF DEATH Dec. 1, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION 2835 Clifton Ave.		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore	
C. Length of stay in Baltimore Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) 2835 Clifton Ave.	
5. SEX female	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) widowed	8. DATE OF BIRTH Feb. 19, 1873
9. AGE (In years, last birthday) 77		10. Under 1 Year Months Days 11. Under 24 Hours Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Dasch		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mr. John C. Dorsey		ADDRESS 3136 Clifftmont Ave.	
18. 420.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CORONARY THROMBOSIS DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. ARTERIO-SCLEROTIC DUE TO CARDIO VASCULAR DISEASE WITH HYPERTENSION OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		INTERVAL BETWEEN ONSET AND DEATH 3 days. 10 yrs.	
19A. DATE OF OPERATION 0		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from March 10, 1948 , to DEC 1 , 1950, that I last saw the deceased alive on Dec 1 , 1950, and that death occurred at 8 P. m. , from the causes and on the date stated above.			
23A. SIGNATURE Norman R. Kleiman		23B. ADDRESS 3803 Edmondson Ave	
23C. DATE SIGNED 12/2/50.			
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/4/50	
24C. NAME OF CEMETERY OR CREMATORY Woodlawn Cem.		24D. LOCATION (City, town, or county) (State) Woodlawn, Md.	
DATE RECEIVED BY LOCAL REGISTRAR DEC 2 - 1950		REGISTRAR'S SIGNATURE Huntington Williams	
25. FUNERAL DIRECTOR Wm. J. Dickner & Sons		ADDRESS Baltimore, Md.	

93D

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432
50-10293

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10293

Registered No.

1. NAME OF DECEASED (Type or Print) THERESA F. Blotkamp			2. DATE OF DEATH December 1, 1950		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore		
B. FULL NAME OF HOSPITAL OR INSTITUTION St. Joseph's Hospital			C. CITY OR TOWN (If outside corporate limits, write full name and give township) Baltimore		
C. Length of stay in Baltimore			D. STREET ADDRESS (If rural, give location) 3905 Fair Ave.		
5. SEX F.	6. COLOR OR RACE W.	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH 7-4-1886		9. AGE (In years last birthday) 64
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Wife		10B. KIND OF BUSINESS OR INDUSTRY Own home	11. BIRTHPLACE (State or foreign country) Baltimore		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME John Beran			14. MOTHER'S MAIDEN NAME Mary Ryeis		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO.	17. INFORMANT Lawrence J. Blotkamp		
18. 174X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Leiomysosarcoma of uterus		CAUSE OF DEATH (A) Leiomysosarcoma of uterus DUE TO (B) uterus DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION 0			19B. MAJOR FINDINGS OF OPERATION		
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from November 2, 1950 , to December 1, 1950 , that I last saw the deceased alive on Nov. 30, 1950 , and that death occurred at 7:20a m. , from the causes and on the date stated above.					
23A. SIGNATURE Will Allen		23B. ADDRESS M. D. 1400 N. Caroline St.		23C. DATE SIGNED Dec. 1, 1950	
24A. BURIAL, CREMATION, REMOVAL (Specify) Buried		24B. DATE 12-4-50		24C. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cem. Belair Rd. - Balto. Md.	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.		25. FUNERAL DIRECTOR John C. Miller Address 2425 E. Ching St.			
DATE RECEIVED BY LOCAL REGISTRAR DEC 2 - 1950		REGISTRAR'S SIGNATURE Washington Williams			

7-1-1911

Sept 1911
10-1-1911

10-1-1911

10-1-1911
10-1-1911

000
50-10294
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10294
Registered No.

1. NAME OF DECEASED (Type or Print)		SYLVIA GAY		2. DATE OF DEATH December 2, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY			
B. FULL NAME OF HOSPITAL OR INSTITUTION South Baltimore General Hospital		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore			
c. Length of stay in Baltimore		D. STREET ADDRESS (If rural, give location) 1013 Herndon Court			
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH SEPT 25, 1916	9. AGE (In years last birthday) 34	10. Under 1 Year Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK		10B. KIND OF BUSINESS OR INDUSTRY LOCKE INSULATOR		11. BIRTHPLACE (State or foreign country) WEST VIRGINIA	
13. FATHER'S NAME ARTHUR L. SIMMONS		14. MOTHER'S MAIDEN NAME MAUDE SIMMONS		12. CITIZEN OF WHAT COUNTRY? USA	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS ALBERT GAY 1013 HERNDON CT.	

18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Multiple contusions of brain DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		INTERVAL BETWEEN ONSET AND DEATH	
---	--	----------------------------------	--

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Patapsco Avenue & St. Margaret Street	
21D. TIME (Month) (Day) (Year) (Hour) December 1, 1950 10:00P.M.		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? Pedestrian struck by car (auto)	
22. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input checked="" type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .					
23A. SIGNATURE William H. Brown		23B. CHIEF MEDICAL EXAMINER M.D. ASSISTANT MEDICAL INVESTIGATOR		23C. DATE SIGNED Dec. 2, 1950	
24A. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 12/5/50		24C. NAME OF CEMETERY OR CREMATORY FRANKLIN W. VA.	
24D. LOCATION (City, town, or county) (State) FRANKLIN W. VA.		25. FUNERAL DIRECTOR ADDRESS JOHN F. DENNY, INC 715 LIGHT ST			

220
50-10295

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10295
Registered No.

BIRTH NO. 47319

1. NAME OF DECEASED (Type or Print) Peter L. LISOWSKY, JR.		2. DATE OF DEATH Dec. 1, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION 1329 N. Linwood Ave.		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore	
D. STREET ADDRESS (If rural, give location) 1329 N. Linwood Ave.		9. AGE (In years last birthday) 4	
5. SEX Male 6. COLOR OR RACE White		7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) SINGLE	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	
13. FATHER'S NAME PETER L. LISOWSKY		14. MOTHER'S MAIDEN NAME NORMA PLASKOVITZ	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT MR. PETER L. LISOWSKY		ADDRESS N. LINWOOD AVE	

18. 057.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Acute meningococcus septicemia xxxxx (Waterhouse-Friderichsen syndrome)		INTERVAL BETWEEN ONSET AND DEATH
19. CAUSE OF DEATH (A) DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO (C) OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in, or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?

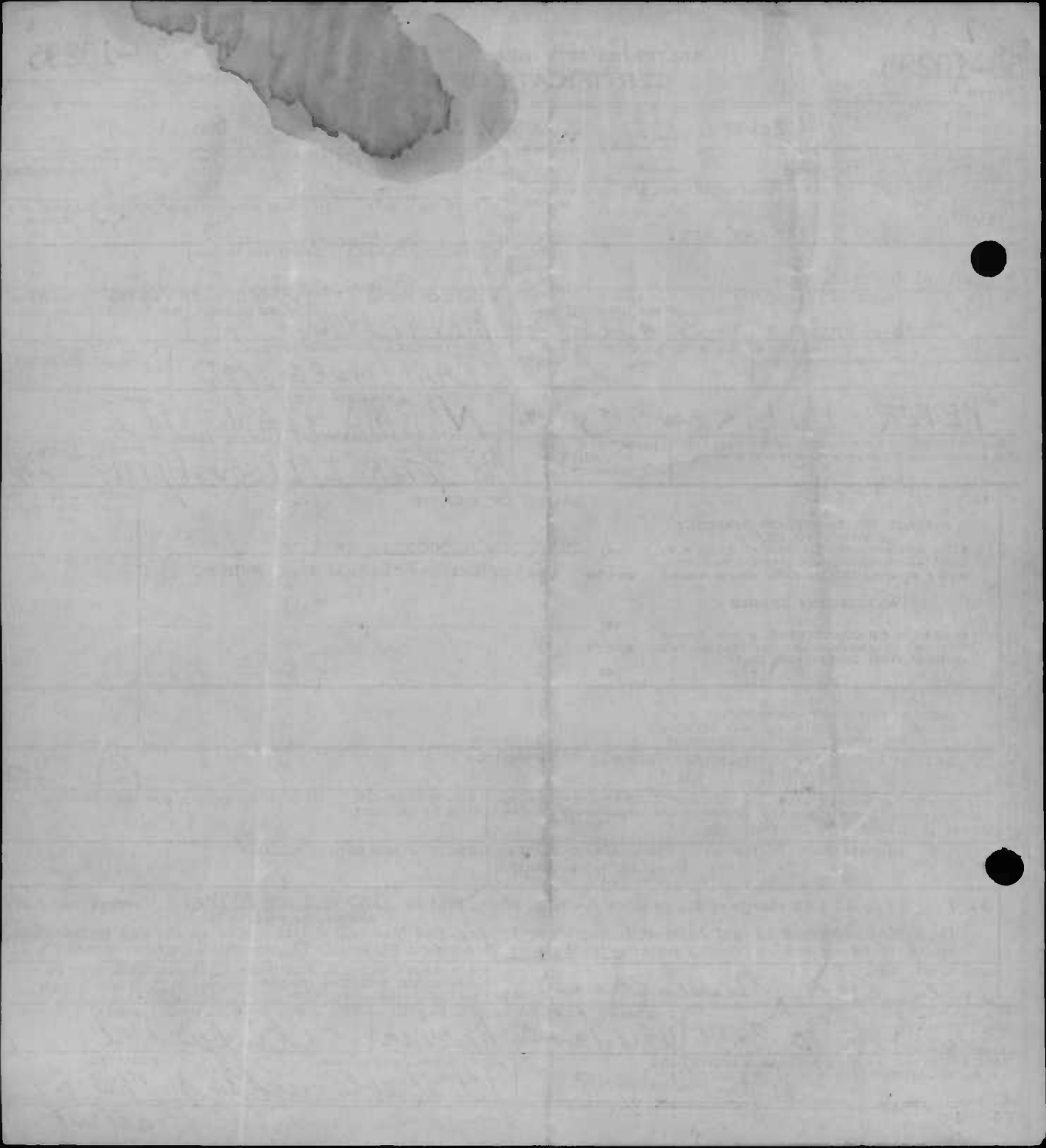
22. I certify that I took charge of the remains described above, held an Inspection & Ing. thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE Stanley K. Duncanson	23B. CHIEF MEDICAL EXAMINER..... ASSISTANT MEDICAL EXAMINER..... MEDICAL INVESTIGATOR.....	23C. DATE SIGNED Dec. 1, 1950
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24A. BURIAL, CREMATION, REMOVAL (Specify) Burial	24B. DATE Dec 3, 50	24C. NAME OF CEMETERY OR CREMATORY Holy Trinity Russian	24D. LOCATION (City, town, or county) (State) Cockbridge Md.
DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE Washington Williams, Jr.	25. FUNERAL DIRECTOR J. A. Grebliauskas	ADDRESS 1905 E 6 Pratt St

DEC 2-1950
VS 151

MEDICAL CERTIFICATION
correct age is especially important in infant deaths



M-200

50-10296

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10296

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Hattie Mass

2. DATE
OF
DEATH

November 27, 1950

3. PLACE OF DEATH:

a. Baltimore City, Maryland

b. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION

873 W. Fayette St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

a. STATE

b. COUNTY

Maryland

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

18-01

d. STREET ADDRESS (If rural, give location)

873 W. Fayette St.

c. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years,
last birthday)10. Under 1 Year
Months: Days11. Under 24 Hours
Hours: Min.

Female

C

Widow

October 10, 1884

66

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

Housewife

11. BIRTHPLACE (State or foreign country)

Warwick Co. V.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Pompey Warr

14. MOTHER'S MAIDEN NAME

maie ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Martha Massey - 208 N. Carrollton Ave.

18. 594 X

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C) DUE TO

None

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT ☐ NOT WHILE
WORK AT WORK22. I hereby certify that I attended the deceased from 10/26th, 1950 to 11/27, 1950 that I last saw the deceased alive on 11/26, 1950, and that death occurred at 7 A.M. from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

D. H. Gurn

M. D.

522 N. Arlington

11/30/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, county) (State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

12-2-1950

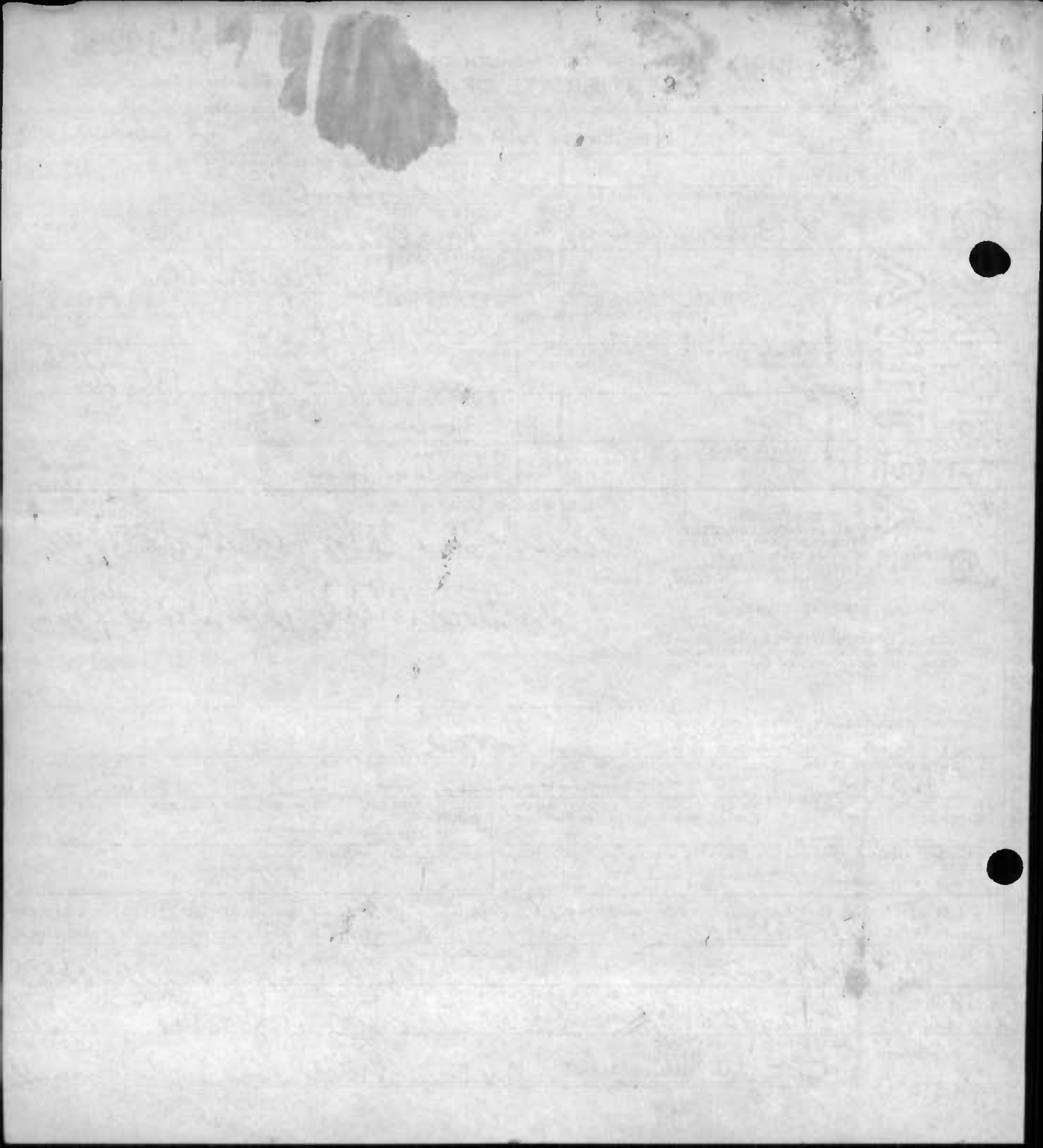
Huntington Williams, M.D.

Mrs. Kate R. Williams - Schreiner

DEC 8 1950

131a

MEDICAL CERTIFICATION



F. 432

50-10297

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50-10297
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

LUCY

FIELDS

2. DATE
OF
DEATH

November 29, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION

1201 Myrtle Avenue

Yrs.
Mos.
Days

C. Length of stay in Baltimore

5. SEX

Female

6. COLOR OR RACE

Colored

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Widow

8. DATE OF BIRTH

Sept. 18, 1887

9. AGE (In years
last birthday)

63

If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Domestic

10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Yorktown Va.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Samuel Shields

14. MOTHER'S MAIDEN NAME

Mary ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Florence Dunn-Shields Place

18. 443 X 1

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) Hypertensive cardiovascular disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.INTERVAL BETWEEN
ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
INJURY

21E. INJURY OCCURRED

WHILE AT
WORK ☐ NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Inspection & Inquiry thereon and from
Autopsy, Inspection or Inquiry
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,
and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

William J. Smith

23B. CHIEF MEDICAL EXAMINER.....☐ASSISTANT MEDICAL EXAMINER.....☒

23C. DATE SIGNED

Nov. 29, 1950

M.D.

MEDICAL INVESTIGATOR.....☐24A. BURIAL, CREMA-
TION, REMOVAL (Specify)DATE RECEIVED BY
LOCAL REGISTRAR

24B. DATE

REGISTRAR'S SIGNATURE

Timothy R. Williams, M.D.

24C. NAME OF CEMETERY OR CREMATORY

Mt. Auburn Cem. Balto.

24D. LOCATION (City, town, or county)

Md.

(State)

25. FUNERAL DIRECTOR

Mrs. Katie R. Williams, Schroeder

ADDRESS 322 X

H-200
50-10298BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50-10298

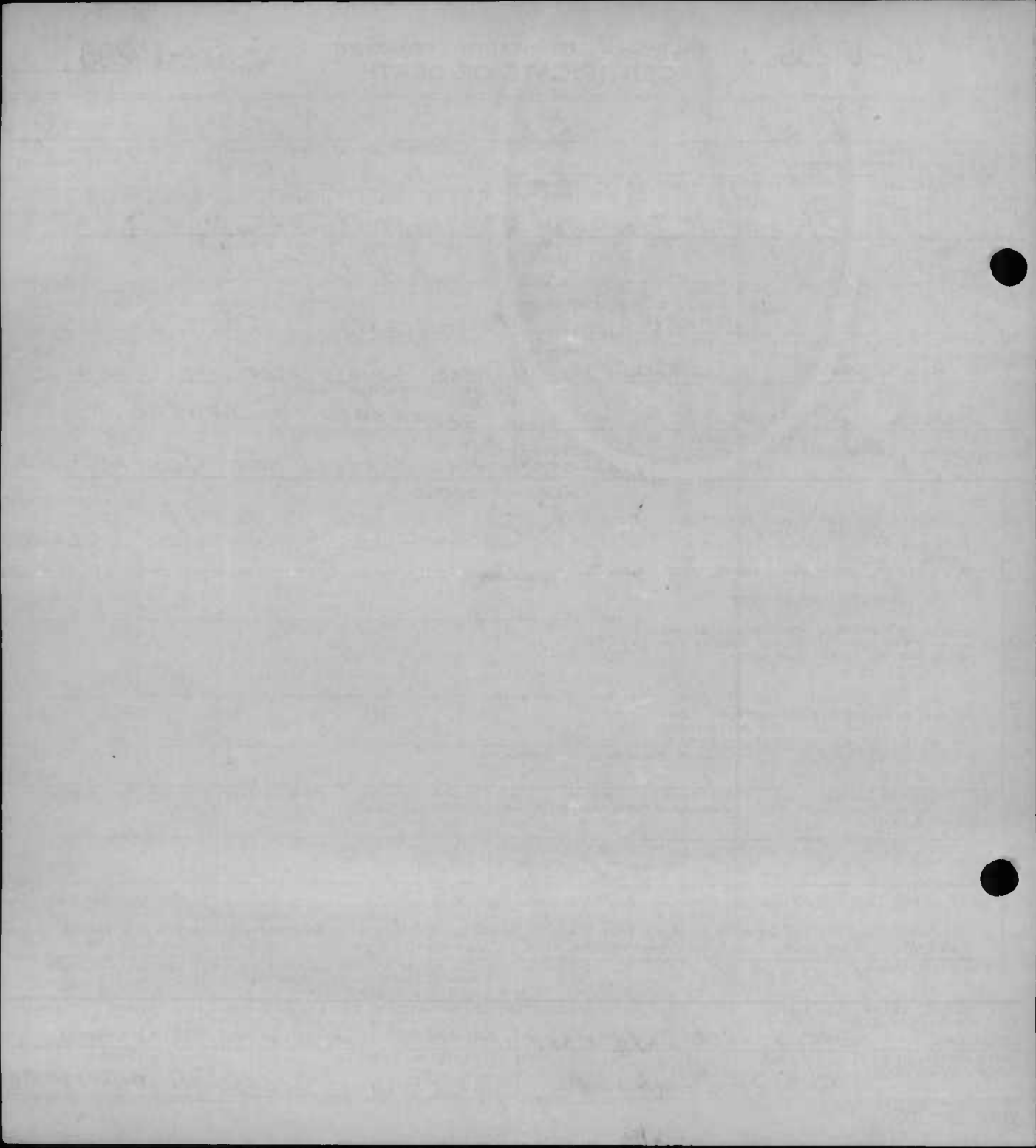
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Ray C. Hook</i>		2. DATE OF DEATH <i>12-2-50</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Carroll</i>			
5. FULL NAME OF HOSPITAL OR INSTITUTION <i>Johns Hopkins Hospital</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Westminster</i> <i>Westminster</i>			
6. LENGTH OF STAY IN BALTIMORE		D. STREET ADDRESS (If rural, give location) <i>R.F.D. #6</i> <i>5600</i>			
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>MARRIED</i>	8. DATE OF BIRTH <i>MARCH 3 1895</i>	9. AGE (in years last birthday) <i>55</i>	10. Under 1 Year Months: Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>TAX ASSESSOR</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>COUNTY</i>		11. BIRTHPLACE (State or foreign country) <i>CARROLL COUNTY MARYLAND</i>	
13. FATHER'S NAME <i>JAMES W. HOOK</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <i>NO</i>		16. SOCIAL SECURITY NO. <i>214-01-0550</i>		14. MOTHER'S MAIDEN NAME <i>ELIZABETH A. BEAVER</i>	
17. INFORMANT <i>MRS MARJORIE HOOK</i>		ADDRESS <i>WESTMINSTER, MD.</i>			
18. <i>422.1</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Intersecur Cordis</i> DUE TO <i>Disease</i>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH <i>6 years</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <i>II</i> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		(B) DUE TO			
(C)					
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that I took charge of the remains described above, held an _____ thereon and from _____ Autopsy, Inspection or Inquiry the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .					
23A. SIGNATURE <i>Robert H. Mindes</i>		23B. CHIEF MEDICAL EXAMINER..... M.D. ASSISTANT MEDICAL EXAMINER..... MEDICAL INVESTIGATOR.....		23C. DATE SIGNED <i>12-2-50</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>DEC. 5, 1950</i>		24C. NAME OF CEMETERY OR CREMATORY <i>DEER PARK CEMETERY</i>	
DATE RECEIVED BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE <i>Winston Williams</i>		25. FUNERAL DIRECTOR <i>J. FRANCIS REESE</i>	
				ADDRESS <i>WESTMINSTER, MD.</i>	

MEDICAL CERTIFICATION

DEC 3-1950

250 92

92D ✓



5-260

50-10299

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50-10299
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

BESSIE SUGAR

2. DATE
OF
DEATH 12/1/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF
HOSPITAL OR
INSTITUTION (If not in hospital or institution, give street address or location)

4613 Park Heights Avenue

C. Length of stay in Baltimore

30 Years

Yrs.
Mos.
Days

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Married

10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR
INDUSTRY

Own Home

13. FATHER'S NAME

Jacob Silverman

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

8. DATE OF BIRTH

Aug. 3, 1892

9. AGE (In years
last birthday)

58

11 Under 1 Year
Months: Days11 Under 24 Hours
Hours: Min.

11. BIRTHPLACE (State or foreign country)

Russia

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

14. MOTHER'S MAIDEN NAME

Unknown

17. INFORMANT

ADDRESS

Mr. Fredel Sugar 2912 Allendale Road

18. 155X I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) DUE TO

Carcinoma, gall bladder about
with metastases 10 months

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

April 1950

19B. MAJOR FINDINGS OF OPERATION

extensive carcinoma - gall bladder - liver
intestines

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
INJURY

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from March 1, 1950, to Dec 1, 1950 that I last saw the
deceased alive on Dec 1, 1950, and that death occurred at 5 p.m., from the causes and on the date stated above.

23A. SIGNATURE

Dr. Herman Seidel

23B. ADDRESS

2404 Eutan Rd

23C. DATE, SIGNED

12/2/50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

12/3/50

24C. NAME OF CEMETERY OR CREMATORY

Adath Israel Anshe Sfard

24D. LOCATION (City, town, or county)

German Hill Rd. Balto, Maryland

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

(17)

Sol Leinsox & Bros. 1124-26 W. North Avenue

DEC 3-1950

46 F

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

STATE OF NEW YORK

County of _____

No. _____

Date _____

Time _____

Place _____

Age _____

Sex _____

Color _____

Height _____

Weight _____

Build _____

W-452

50-10300

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10300

Registered No.

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH	
		MAURICE WILLIAMS		12/1/50	
3. PLACE OF DEATH:					
A. Baltimore City, Maryland					
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION					
909 W. North Avenue					
C. Length of stay in Baltimore					
45 Years					
4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)					
A. STATE					
Maryland					
B. COUNTY					
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township)					
Baltimore					
D. STREET ADDRESS (If rural, give location)					
909 W. North Avenue					
5. SEX		6. COLOR OR RACE		7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	
Male		White		Married	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY			
Barber		Own Shop			
13. FATHER'S NAME					
Adolph Williams					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)					
(If yes, give war or dates of service)					
16. SOCIAL SECURITY NO.					
17. INFORMANT					
Mrs. Ida Williams					
ADDRESS					
909 W. North Ave.					

IB. 420.1		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) Acute Left Ventricular Failure		1/2 hr	
DUE TO					
ANTECEDENT CAUSES		(B) Chr coronary insuff			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		DUE TO			
		Cardiac Hypertrophy & Dilatation			
II		(C)			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		WHILE AT <input type="checkbox"/> WORK NOT WHILE <input type="checkbox"/> AT WORK			
22. I hereby certify that I attended the deceased from March 1, 1943 to Dec 1, 1950, that I last saw the deceased alive on Dec 1, 1950, and that death occurred at 11:15 PM, from the causes and on the date stated above.					
23A. SIGNATURE		23B. ADDRESS		23C. DATE SIGNED	
D. P. Bernard J. Cole		March and Ast		12-1-50	
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
Burial		12/3/50		Chizuk Amuno (Rogers Ave.)	
				Baltimore	
				Maryland	
DATE RECEIVED BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR	
				Sol Levinson & Bros. 1124-26 W. North Avenue	

DEC 3 1950

7408F

952

UNITED STATES DEPARTMENT OF THE INTERIOR
BUREAU OF LAND MANAGEMENT

WYOMING

SECTION 36
TOWNSHIP 14 N
RANGE 10 E
COUNTY OF SHERIDAN
STATE OF WYOMING

DEPARTMENT OF THE INTERIOR

BUREAU OF LAND MANAGEMENT

WYOMING

SECTION 36

TOWNSHIP 14 N

RANGE 10 E

COUNTY OF SHERIDAN

STATE OF WYOMING

DEPARTMENT OF THE INTERIOR

BUREAU OF LAND MANAGEMENT

WYOMING

SECTION 36

TOWNSHIP 14 N

RANGE 10 E

COUNTY OF SHERIDAN

STATE OF WYOMING

DEPARTMENT OF THE INTERIOR

BUREAU OF LAND MANAGEMENT

WYOMING

D-543

50-10301

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10301

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Bessie M. Donaldson

2. DATE
OF
DEATH

Dec 2, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

1501 Byrd St

B. FULL NAME OF

INSTITUTION

(If not in hospital or institution, give street address or location)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

B. COUNTY

before admission)

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Maryland
Baltimore

24-04

D. STREET ADDRESS (If rural, give location)

1501 Byrd St

Length of stay in Baltimore

Life

Yrs.
Mos.
Days

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

July 1, 1890

9. AGE (in years
last birthday)

60 yrs

11 Under 1 Year
Months: Days11 Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life even if retired)

at home

10B. KIND OF BUSINESS OR
INDUSTRY

Housewife

11. BIRTHPLACE (State or foreign country)

Balt Md

12. CITIZEN OF
WHAT COUNTRY?

U.S.

13. FATHER'S NAME

David W. Hooper

14. MOTHER'S MAIDEN NAME

Mary L. Preston

15. WAS DECEASED EVER IN U. S. ARMED FORCES
(Yes, no or unknown) (If yes, give war or dates of service)

no

no

16. SOCIAL
SECURITY NO.

no

17. INFORMANT

ADDRESS

Bernard J. Donaldson 1501 Byrd St

18. 153X I CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A)

DUE TO

Carcinoma of descend- 3 years
ing Colon

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

cachexia

(C)

INTERVAL BETWEEN
ONSET AND DEATH

6 mos.

II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

1947

19B. MAJOR FINDINGS OF OPERATION

Resection of part of Colon

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec 2, 1950, that I last saw the
deceased alive on 19 and that death occurred at 9:40 a.m., from the causes and on the date stated above.

23A. SIGNATURE

Isaac Miller M. D.

23B. ADDRESS

1225 So. Clark St

23C. DATE SIGNED

12/2/50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

Dec 5, 1950

24C. NAME OF CEMETERY OR CREMATORY

Bedon Hill

24D. LOCATION (City, town, or county)

A. A. B.

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

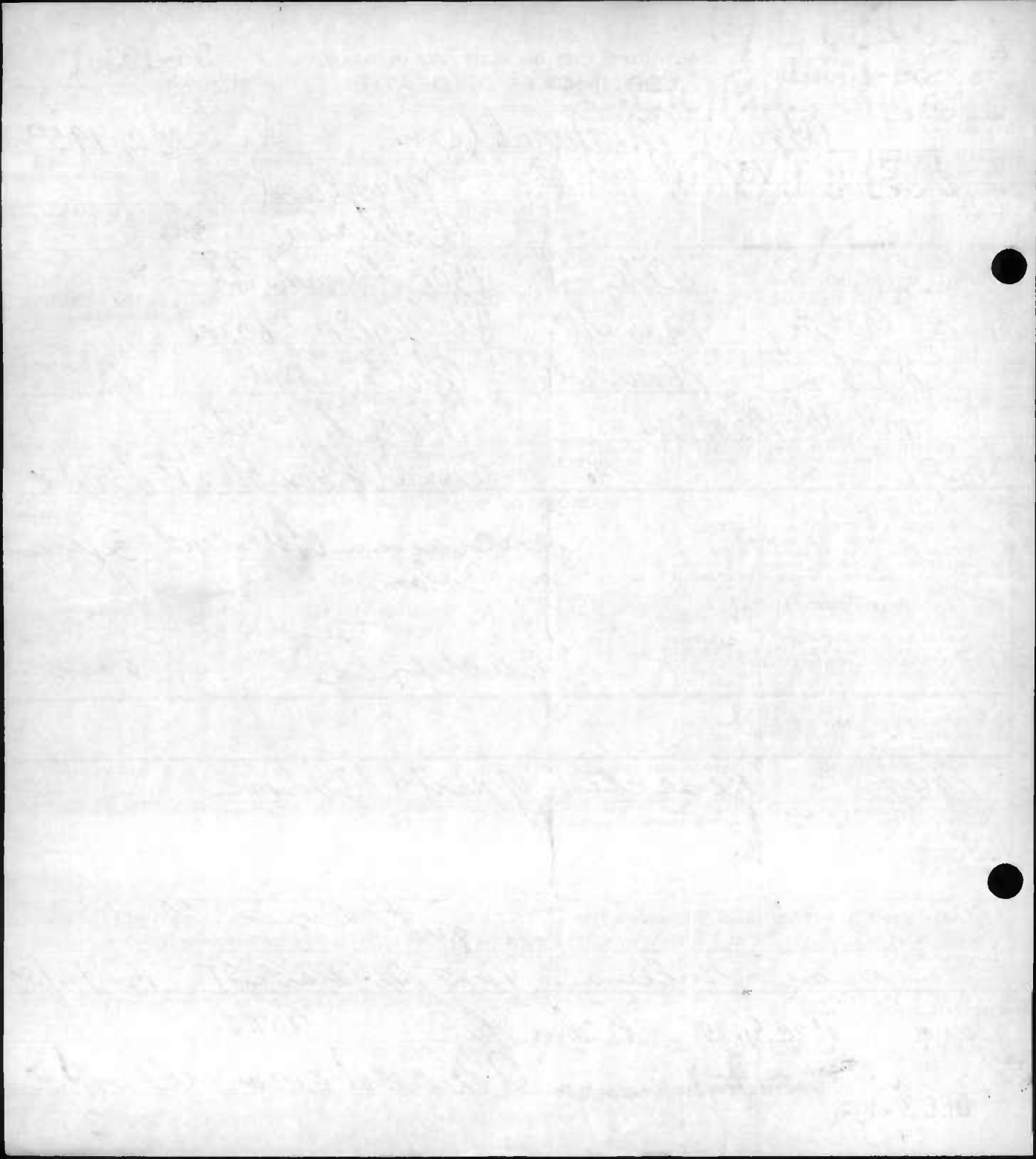
ADDRESS

A. Howard Evans 1400 S. Charles St

DEC 3 - 1950

46E

MEDICAL CERTIFICATION



50-10302

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10302

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Joseph David Leibowitz

2. DATE
OF
DEATH

1 Dec. 50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)

A. STATE

Md.

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION

Anwar

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Balto.

15-03

D. STREET ADDRESS (If rural, give location)

1607 Ruxton Ave

Length of stay in Baltimore

50

Yrs.
Mos.
Days

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

W

8. DATE OF BIRTH

9. AGE (In years last birthday)

10 Under 1 Year

Months: Days

11 Under 24 Hours

Hours: Min.

30

10A. USUAL OCCUPATION (Give kind of work done during last year, even if retired)

Retired

10B. KIND OF BUSINESS OR INDUSTRY

Tailor

11. BIRTHPLACE (State or foreign country)

Russia

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Jacob

14. MOTHER'S MAIDEN NAME

Dora

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Samuel Leibowitz 4404 Forest Park

18. 443X I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

Bronchopneumonia

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

Recent cerebral Thrombosis

DUE TO

(C)

HCVD & cardiac enlarg.

INTERVAL BETWEEN ONSET AND DEATH

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from 24 Nov. 1950, to 1 Dec., 1950 that I last saw the deceased alive on 1 Dec., 1950, and that death occurred at 8:15 A.M., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

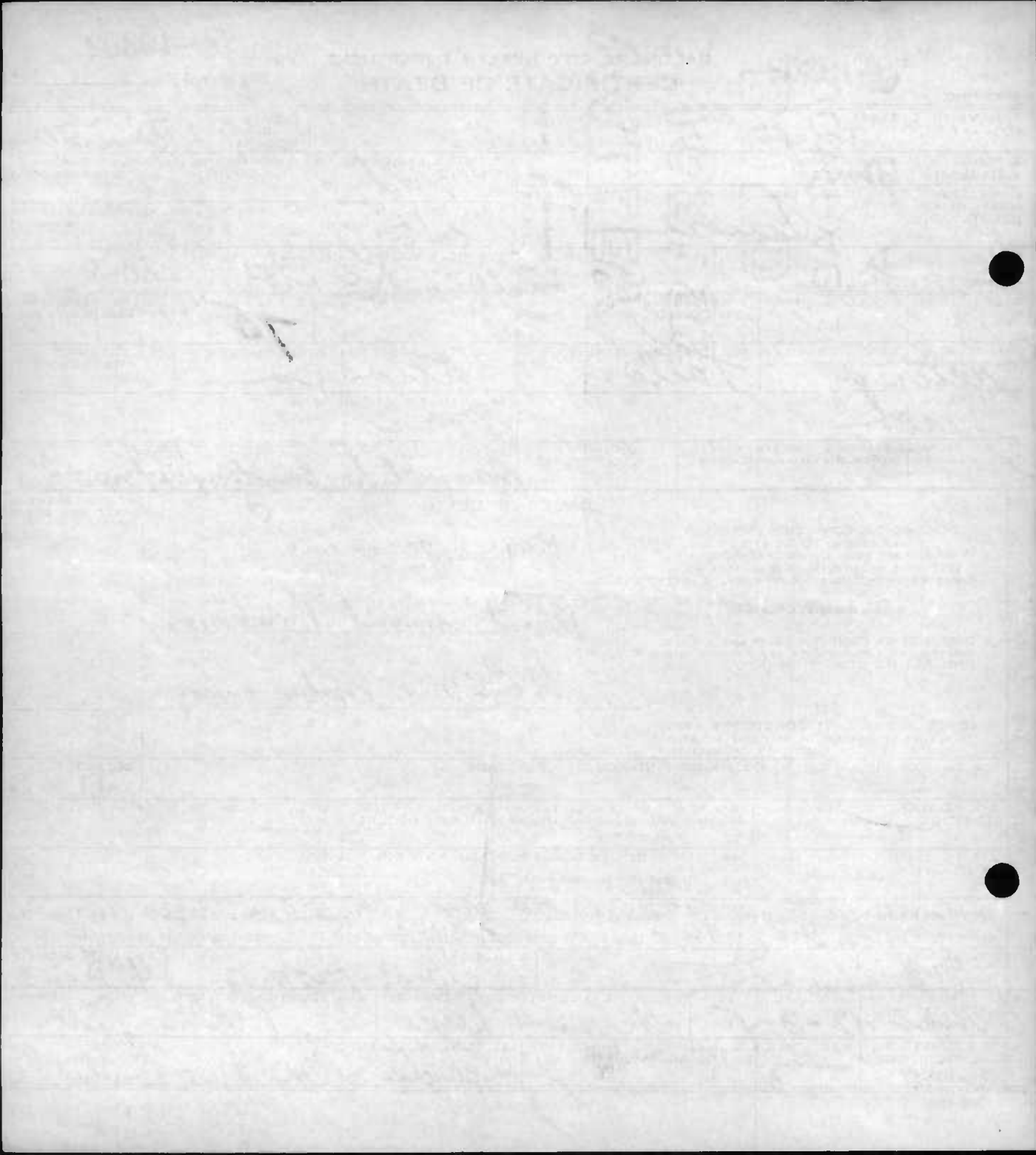
25. FUNERAL DIRECTOR

ADDRESS

EC 3-1950

VS 150

93D



K-321

50-10303

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10303

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Joseph Katzoff

2. DATE
OF
DEATH

12-1-50.

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF
HOSPITAL OR
INSTITUTION

Levindale

C. Length of stay in Baltimore

50

Yrs.
Mos.
Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Md

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

Levindale 27-17

5. SEX

male

6. COLOR OR RACE

white

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

widowed

10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

retired

10B. KIND OF BUSINESS OR
INDUSTRY

Peddler

13. FATHER'S NAME

Not known

8. DATE OF BIRTH

7-2

9. AGE (In years
last birthday)11 Under 1 Year
Months: Days12 Under 24 Hours
Hours: Min.

11. BIRTHPLACE (State or foreign country)

Russia

12. CITIZEN OF
WHAT COUNTRY?

14. MOTHER'S MAIDEN NAME

Eva

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Harry Caplan 3814 Derby Manor Dr

18. 332X

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) DUE TO

Cerebral Thrombosis

INTERVAL BETWEEN
ONSET AND DEATH

4 weeks

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

Arteriosclerosis

(C)

II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER-
LYING OR CONTRIBUTING
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT
WORK ☐ NOT WHILE
AT WORK ☐22. I hereby certify that I attended the deceased from Jan 16, 1948, to Dec 1, 1950, that I last saw the
deceased alive on 12-1, 1950, and that death occurred at 2:20 p. m., from the causes and on the date stated above.

23A. SIGNATURE

Jerome J. Plumberg, M.D.

23B. ADDRESS

Levindale Home

23C. DATE SIGNED

12-1-50.

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

12-3-50

24C. NAME OF CEMETERY OR CREMATORY

Rosedale

24D. LOCATION (City, town, or county) (State)

Baltimore Md

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

William Williams, M.D.

25. FUNERAL DIRECTOR

Jack Lewicki 2100 Eutaw Pl

ADDRESS

DEC 3 - 1950

VS 150

29068

8312

MEDICAL CERTIFICATION

Low Callan

~~7111 1611~~

1611 1611 1611

2003 2003 2003

Good

5-526

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10304

Registered No.

BIRTH NO. 50-10304

1. NAME OF DECEASED
(Type or Print)

A. Samuel Singer

2. DATE
OF
DEATH

30 Nov '50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF
HOSPITAL OR
INSTITUTION

Sinai Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution; residence
before admission)

A. STATE

B. COUNTY

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

5209 Wilton Heights Ave

Length of stay in Baltimore

60

Yrs.
Mos.
Days

5. SEX

male

6. COLOR OR RACE

white

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

married

10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Retired

10B. KIND OF BUSINESS OR
INDUSTRY

Social Security Board

13. FATHER'S NAME

Elliott

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

11. BIRTH PLACE (State or foreign country)

Russia

12. CITIZEN OF
WHAT COUNTRY?

14. MOTHER'S MAIDEN NAME

Leah

17. INFORMANT

ADDRESS

Milton Singer 4001 Cottage Ave

18. 422.2

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A)

Pulmonary Edema

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

Myocardial Insufficiency

DUE TO

(C)

INTERVAL BETWEEN
ONSET AND DEATHII
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT ☐ NOT WHILE
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 30 Nov, 1950, to 30 Nov, 1950 that I last saw the
deceased alive on 30 Nov, 1950 and that death occurred at 2:23 P.M., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

DEC 3 - 1950

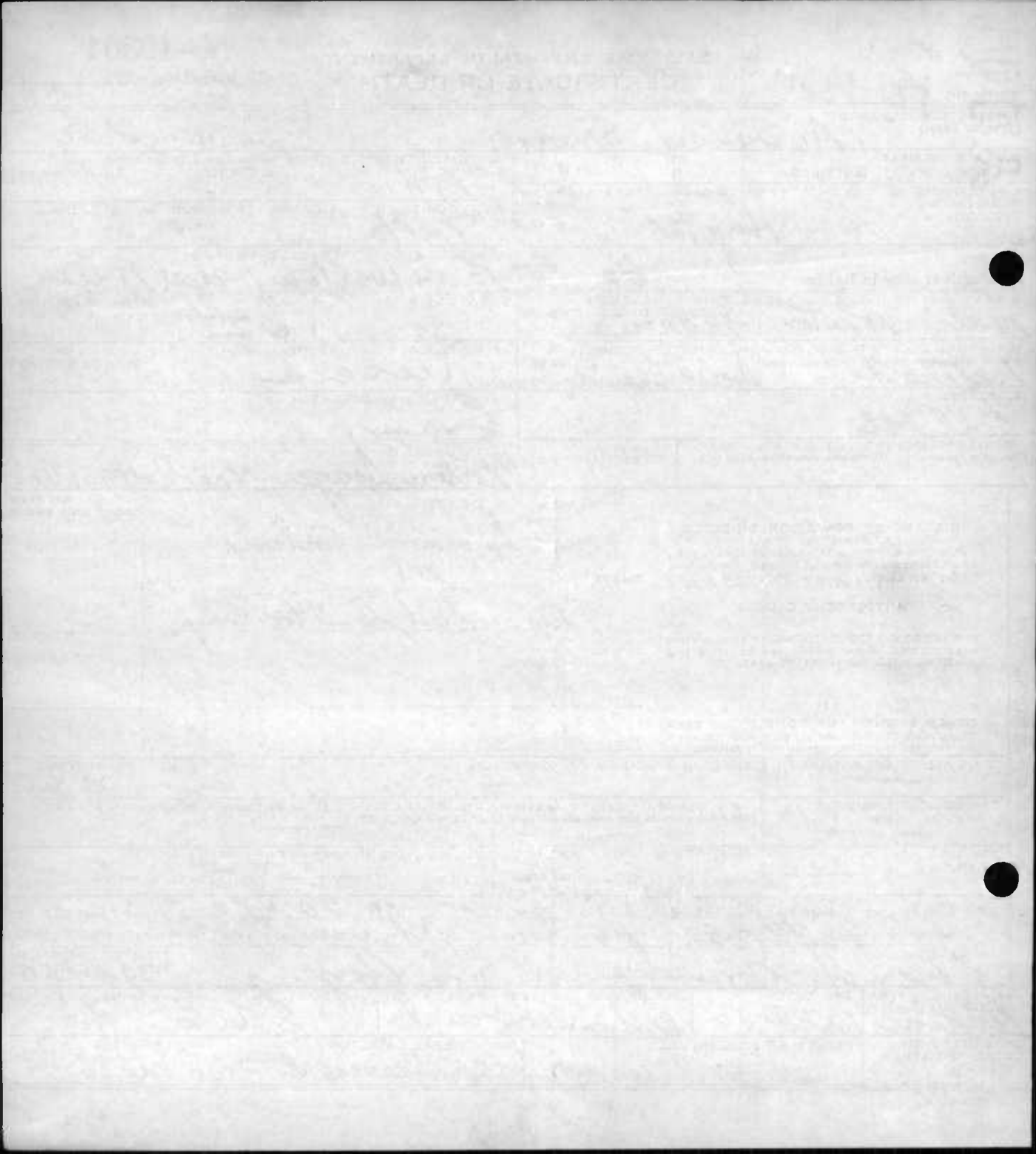
2100 Eutan Pl

VS 150

390 91

93E

MEDICAL CERTIFICATION



M-250
50-10305BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50-10305
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

REBECCA MARIN

2. DATE
OF
DEATH

12-1-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF
HOSPITAL OR
INSTITUTION

Levindale

C. Length of stay in Baltimore

38

Yrs.
Mos.
Days

4. USUAL RESIDENCE (Where deceased lived, if institution: residence

A. STATE

B. COUNTY

before admission)

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

206 No High St

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR
INDUSTRY

13. FATHER'S NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

18. 491X
DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

CAUSE OF DEATH

(A)

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

Diabetes mellitus

INTERVAL BETWEEN
ONSET AND DEATH

5 days

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11-24, 1950, to 12-1, 1950, that I last saw the
deceased alive on 12-1, 1950, and that death occurred at 3 a.m., from the causes and on the date stated above.

23A. SIGNATURE

Henry Nagel

M. D.

23B. ADDRESS

Levindale Home

23C. DATE SIGNED

12-1-50

24. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

12-3-50

24C. NAME OF CEMETERY OR CREMATORY

Hebrew Friendship

24D. LOCATION (City, town, or county)

Balto, Md

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

Jack Lewis 2100 Canton Pl

DEC 3 - 1950

VS 150

61

10-10-10
RECEIVED
MAY 10 1910

RECEIVED
MAY 10 1910
MAY 10 1910

RECEIVED
MAY 10 1910
MAY 10 1910

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MAY 10 1910
MAY 10 1910

RECEIVED
MAY 10 1910
MAY 10 1910

M-535
50-10306BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10306

Registered No.

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Joseph J. Monaghan</i>		2. DATE OF DEATH <i>11/30/50</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <i>433 Janson</i>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>MD</i> B. COUNTY <i>Janson St</i>			
B. FULL NAME OF HOSPITAL OR INSTITUTION		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore 224-01</i>			
C. Length of stay in Baltimore <i>Life</i>		D. STREET ADDRESS (If rural, give location) <i>453 Janson St</i>			
5. SEX <i>m.</i>	6. COLOR OR RACE <i>st.</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>m.</i>	8. DATE OF BIRTH <i>4/20/1875</i>	9. AGE (In years last birthday) <i>75</i>	10. Under 1 Year Months: Days Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Dr. & Clerk</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Retired</i>		11. BIRTHPLACE (State or foreign country) <i>Baltimore</i>	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <i>Laurence Monaghan</i>		14. MOTHER'S MAIDEN NAME <i>Ann O'Brien</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Mrs. J. J. Monaghan</i> ADDRESS	
18. <i>443 X</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH <i>Cerebral Thrombosis</i> (A) DUE TO <i>Arterio Sclerosis,</i> (B) DUE TO <i>Myocardial Infarction</i> (C)		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION <i>0</i>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>Nov 26</i> , 19 <i>50</i> , to <i>Nov 30</i> , 19 <i>50</i> , that I last saw the deceased alive on <i>Nov 30</i> , 19 <i>50</i> , and that death occurred at <i>7:15 p.m.</i> , from the causes and on the date stated above.					
23A. SIGNATURE <i>John E. Schuch</i>		23B. ADDRESS <i>1337 S. Charles St.</i>		23C. DATE SIGNED <i>12/1/50</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>12/4/50</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Cathedral</i>	
24D. LOCATION (City, town, or county) (State) <i>Old Frederick Rd</i>		24E. FUNERAL DIRECTOR <i>J. J. Fickel & Sons</i>		24F. ADDRESS <i>1318 Light</i>	
DATE RECEIVED BY LOCAL REGISTRAR <i>DEC 3 - 1950</i>		REGISTRAR'S SIGNATURE <i>Wm. Williams</i>		25. FUNERAL DIRECTOR ADDRESS	

28-1078

1078

EX

GENERAL STATE OF DEATH

General State of Death
in the State of
New York

Dec 28 1908
New York City
1908

N-450307

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

50-10307

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

William Parker Neilson

2. DATE
OF
DEATH

Dec 2, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

B. COUNTY

before admission)

Md

Balto

B. FULL NAME OF (If not in hospital or institution, give street address or
HOSPITAL OR INSTITUTION Union Memorial Hospital location)

3224 Calvert St. Balto 18 Md.

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Balto. 10

27-14

D. STREET ADDRESS (If rural, give location)

4206 Wickford Rd.

C. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE. MARRIED.

WIDOWED, DIVORCED (Specify)

M

8. DATE OF BIRTH

Nov. 3, 1910

9. AGE (In years

last birthday)

40

If Under 1 Year

If Under 24 Hours

Months: Days

Hours: Min.

10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Banker

10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Texas

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

William P. Neilson Sr.

14. MOTHER'S MAIDEN NAME

Nova Fowler

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

Unknown

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Linda Neilson (wife)

Same

CAUSE OF DEATH

18. 572.1

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A)

Septicemia

DUE TO

INTERVAL BETWEEN
ONSET AND DEATH

4 da.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

Perforated diverticulum sigmoid 5 da.

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

Nov. 28, 1950

19B. MAJOR FINDINGS OF OPERATION

Perforated sigmoid diverticulum

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT WAS UNDER-
LYING OR CONTRIBUTING
CAUSE OF DEATH21B. PLACE OF INJURY (e.g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)
INJURY

21E. INJURY OCCURRED

m.

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov. 28, 1950, to Dec 2, 1950, that I last saw the
deceased alive on Dec 2, 1950, and that death occurred at 1:30 A.M., from the causes and on the date stated above.

23A. SIGNATURE

Alvin Bongelaar

M. D.

23B. ADDRESS

Union Memorial Hospital
3224 Calvert St. Balto

23C. DATE SIGNED

Dec. 3, 1950

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

Dec 4, 1950

24C. NAME OF CEMETERY OR CREMATORY

Druid Ridge

24D. LOCATION (City, town, or county)

Pikesville, Md

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Timothy Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

John O. Mitchell & Sons, 1900 Eutaw Pl

DEC 3 - 1950

VS 150

29071

123

MEDICAL CERTIFICATION

1880-1881

1880-1881

RECEIVED

the
of the
of the
of the

Mr. [illegible]

of the [illegible]

G-630

50-10308

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10308

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Margaret L. Crotty

2. DATE

OF DEATH Dec. 1, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland 3025 Windsor Ave

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

Maryland

B. COUNTY

before admission)

B. FULL NAME OF

(If not in hospital or institution, give street address or location)

HOSPITAL OR
INSTITUTION

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore

10-01

D. STREET ADDRESS (If rural, give location)

1225 Valley St

C. Length of stay in Baltimore

Yrs.

Mos.

Days

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

June 1877

9. AGE (In years-

last birthday)

73

If Under 1 Year

Months: Days

If Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of

work done during most of working life, even if retired)

Mission Helpers

10B. KIND OF BUSINESS OR

INDUSTRY

Folder

11. BIRTHPLACE (State or foreign country)

Baltimore

12. CITIZEN OF

WHAT COUNTRY?

U. S.

13. FATHER'S NAME

David Crotty

14. MOTHER'S MAIDEN NAME

Margaret Walsh

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL

SECURITY NO.

17. INFORMANT

ADDRESS

Miss Mary E. Connelly 1225 Valley St

18. 331X I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A)

Cerebral Hemorrhage

Dec 1st - 1950

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

DUE TO

(B)

Arterio-Sclerotic Cerebral

2 year

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m.

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐22. I hereby certify that I attended the deceased from Jan 1st, 1949, to Dec 1st, 1950, that I last saw the
deceased alive on Dec 1st, 1950, and that death occurred at 12:30 p.m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

M. D.

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

DEC 3-1950

Rita Wiedefeld

900 E. Biddle St

643 8W

83a

MEDICAL CERTIFICATION

15 26 1941
J. A. B. 1941

CERTIFICATE OF DEATH

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address Forest Park & Windsor Mill Rd.
(c) Hospital or institution: Kernan Hospital for Crippled Children
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 9 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County city
(c) City or town Baltimore, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1817 Hope St. (If rural give location) 9-09
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3 (a) FULL NAME

Patricia A. Kreipl

3 (b) If veteran, name war

None

3 (c) Social Security Account

No. None

4. Sex

F

5. Color or race

W

6 (a) Single, married, widowed, or divorced

single

6 (b) Name of husband or wife

6 (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) June 28, 1941

8. AGE: Years Months Days If less than one day

9

5

2

hr.

min.

9. Birthplace Baltimore, Md.

(Town, county, and state)

10. Usual Occupation

none

11. Industry or business

FATHER

12. Name Joseph A. Kreipl

13. Birthplace Balto: Md.

MOTHER

14. Maiden Name Doris Jane Johnson

15. Birthplace Balto: Md.

16 (a) Informant Hospital Records

(b) Address Windsor Mill Rd. & Forest Park Ave

17 (a) Burial

(Burial, cremation, or removal)

(b) Date thereof Dec. 4th 1950

(month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Belair Rd. Balto: Md.

18 (a) Funeral director George J. Ruth, Inc.

(b) Address 1735 Harford Avenue

19 (a) 1950

(Date received by registrar)

Winston Williams

(Signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH 30 Nov 1950, at 8:25 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 29 Nov 1950 to 30 Nov 1950, and that I last saw her alive on 30 Nov 1950.

Immediate cause of death

Cardiac arrest

Due to At. pulmonary collapse and mediastinal shift

Due to _____

Other Conditions spina lipida, calcaneo-valgus foot, scales, multiple sclerosis
(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation: _____

of autopsy: _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence _____ at _____ M

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? _____ While at work? _____ (Specify type of place)

(e) Means of injury _____

23. Signature Winston Williams

M. D.

Address _____ Date signed _____

INSTRUCTIONS FOR MEDICAL CERTIFICATION

WHAT IS A "CAUSE OF DEATH"?

For the death certificate, a cause-of-death statement should involve only those disease entities which have contributed to the death. Symptoms or findings are not wanted except as they are needed in determining the underlying cause of death.

DEFINITION OF IMMEDIATE CAUSE OF DEATH:

The last of a series of disease entities which contribute to a death will be known as the immediate cause of death. When there is only one disease entity present, this becomes the immediate cause of death.

DEFINITION OF UNDERLYING CAUSE OF DEATH:

The disease entity which initiates the series of disease entities resulting in death will be known as the underlying cause of death. When there is only one disease entity present, the underlying cause of death and the immediate cause of death are considered to be identical. The underlying cause of death should be written in the space following the words *due to* and should be stated in reverse order of occurrence from the immediate cause of death.

If there is more than one cause contributing to the death, the physician is expected to underline that particular ONE

cause to which, in his opinion, the death should be charged for purpose of statistical tabulation.

DEFINITION OF OTHER CONDITIONS:

Other conditions, existing coincidentally, which might have contributed to the risk of dying, but are not related to any clear-cut manner to the immediate or underlying cause of death, should be given under this item. Pregnancy within 3 months of death should be included because so many times causes of maternal death are missed unless this information is noted.

If operation or autopsy findings exist, the physician is requested to list the major conditions which have weight in deciding the underlying cause to which the death should be charged statistically.

For additional discussion of this subject see **PHYSICIANS' HAND-BOOK ON BIRTH AND DEATH REGISTRATION** issued by the U. S. Bureau of the Census. A copy of this booklet may be secured from the Baltimore City Health Department.

B-200
50-10310BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50-10310
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Lawrence H. Busch

2. DATE
OF

DEATH Nov. 30th 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, If institution: residence

A. STATE

Maryland

B. COUNTY

City

(before admission)

B. FULL NAME OF (If not in hospital or institution, give street address or
HOSPITAL OR location)
INSTITUTION 1720 Montpelier Street

C. CITY OR TOWN

Baltimore

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

1720 Montpelier Street

c. Length of stay in Baltimore

Life

Yrs.
Mos.
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)
Widowed

8. DATE OF BIRTH

April 3, 1880

9. AGE (In years
last birthday)

70

11 Under 1 Year
Months: Days

7 27

11 Under 24 Hours
Hours: Min

✓ ✓

10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR
INDUSTRY

Elevator Operator (Retired) Bank Building

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF
WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME

Lawrence Busch

BLDG. OPERATION

14. MOTHER'S MAIDEN NAME

Sophia Koehler

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

None

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Miss. Mary L. Lipp-I448 Aisquith Street

18. 154X

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A) Carcinoma, Rectum

DUE TO

1 year

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.(C) Benign prostatic hypertrophy
Generalized Arteriosclerosis5 years
5 years

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e.g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April 1, 1947, to Nov. 30, 1950 that I last saw the
deceased alive on Nov. 30, 1950, and that death occurred at 9:00 p.m., from the causes and on the date stated above.

23A. SIGNATURE

Wm. H. Greener

M. D.

23B. ADDRESS

1520 E. 33rd St.

23C. DATE SIGNED

12.1.50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)
Burial

24B. DATE

12-4-50

24C. NAME OF CEMETERY OR CREMATORY

Holy Redeemer Cemetery

24D. LOCATION (City, town, or county)

Belair Rd. Balto: Md.

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

DEC 3 - 1950

25. FUNERAL DIRECTOR ()

ADDRESS

George J. Ruth, Inc. - 1735 Harford Avenue

VS 150

761 74

467

100-10310

DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

100-10310

1. Name of deceased: _____

2. Sex: _____

3. Age: _____

4. Date of birth: _____

5. Place of birth: _____

6. Date of death: _____

7. Time of death: _____

8. Cause of death: _____

9. Place of death: _____

10. Signature of physician: _____

11. Signature of registrar: _____

12. Signature of informant: _____

50-10311

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10311

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)~~Antoinette~~ Antoinette L. Kronner2. DATE
OF
DEATH

Dec. 1, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland Balto. Md.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Md.

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION

Ashburton Nur, Home

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Balto.

D. STREET ADDRESS (If rural, give location)

5113 St Georges Ave.

C. Length of stay in Baltimore

Life

Yrs.
Mos.
Days

5. SEX

F

6. COLOR OR RACE

W

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)
Married

8. DATE OF BIRTH

Apr. 17, 1887

9. AGE (in years
last birthday)

63

If Under 1 Year
Months: Days
If Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

None

10B. KIND OF BUSINESS OR
INDUSTRY

None

11. BIRTHPLACE (State or foreign country)

Baltimore Md.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Joseph Woods

14. MOTHER'S MAIDEN NAME

Katherine Bollman

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown)

No

(If yes, give war or dates of service)

16. SOCIAL
SECURITY NO.
None

17. INFORMANT

ADDRESS

Mr. Frank Kronner 1635 E. 32nd St.

18. 331X I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A)

DUE TO

Cerebral Hemorrhage

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE, (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

Arteriosclerosis

(C)

II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov 30 1950, to Dec 1, 1950 that I last saw the
deceased alive on Nov 30 1950. and that death occurred at 11 30 m., from the causes and on the date stated above.

23A. SIGNATURE

Frank J. Geraghty M. D.

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

Dec. 4 50

24C. NAME OF CEMETERY OR CREMATORY

Moreland Mem.

24D. LOCATION (City, town, or county)

Taylor Ave.

Md.

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Linton Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

Paul A. Heemann 6067 Harford Rd.

DEC 3 1950

83a

MEDICAL CERTIFICATION

Dr. Garra

5-500
50-10312BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10312

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) George H. Sohn			2. DATE OF DEATH Dec. 1, 1950		
3. PLACE OF DEATH: A. Baltimore City, Maryland Baltimore			4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE Md. B. COUNTY Balto.		
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION Beech Hill Con. Home			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore Md. 27-44		
c. Length of stay in Baltimore Life			D. STREET ADDRESS (If rural, give location) 3308 Bayone Ave. Bayone		
5. SEX M	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widower	8. DATE OF BIRTH March 30, 1889		9. AGE (in years last birthday) 61
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician		10B. KIND OF BUSINESS OR INDUSTRY Roland Electric	11. BIRTHPLACE (State or foreign country) Baltimore Md.		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Jacob Sohn		14. MOTHER'S MAIDEN NAME Anna C. Zink			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. 212-01-3015	17. INFORMANT ADDRESS Mr. Henry Zohn 3308 Bayone Ave.		

18. 142.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Carcinoma Parotid Gland 19 mos DUE TO (A) _____ ANTECEDENT CAUSES (B) _____ DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) _____ OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	INTERVAL BETWEEN ONSET AND DEATH 19 mos
---	--

19A. DATE OF OPERATION Dec 1, 1950	19B. MAJOR FINDINGS OF OPERATION Carcinoma	20. AUTOPSY? YES <input type="checkbox"/> ND <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE <input type="checkbox"/> WORK AT WORK	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 1950 to Dec 1, 1950, that I last saw the deceased alive on Dec 1, 1950, and that death occurred at 7:30 A.M., from the causes and on the date stated above.

23A. SIGNATURE Louis Krause M. D. 23B. ADDRESS 1118 Chase St 23C. DATE SIGNED Dec 3-50

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial	24B. DATE dec. 4 50	24C. NAME OF CEMETERY OR CREMATORY Immanuel	24D. LOCATION (City, town, or county) (State) Grindon Lane Balto Md.
DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE L. Williams	25. FUNERAL DIRECTOR Paul A. Heemann	ADDRESS 6067 Harford Rd.

DEC 3 1950

51524

55E

Dr. Krause

426

550-10313

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH550-10313
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

MACK

FULKERSON

2. DATE
OF
DEATH

December 1, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION

Baltimore City Morgue

C. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

3/2/1897

9. AGE (In years
last birthday)

53

10. Under 1 Year

Months: Days

11. Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

MACHINIST

10B. KIND OF BUSINESS OR
INDUSTRY

Mid Day Dock

11. BIRTHPLACE (State or foreign country)

Oregon

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

215-16-3394

17. INFORMANT

ADDRESS

Anna Sokolowski 813 Glen St

18. 443X

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) Hypertensive cardiovascular disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Inspection & Inquiry thereon and from
Autopsy, Inspection or Inquiry
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,
and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

William V. Brown

M.D.

23B. CHIEF MEDICAL EXAMINER..... ☐ASSISTANT MEDICAL EXAMINER..... ☒MEDICAL INVESTIGATOR..... ☐

23C. DATE SIGNED

Dec. 2, 1950

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

12/5/50

24C. NAME OF CEMETERY OR CREMATORY

Glen Haven

24D. LOCATION (City, town, or county)

A. A. Co. Md

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Thurston Williams, M.D.

25. FUNERAL DIRECTOR

R. H. Cr. B. M. Walter

ADDRESS

R. H. Cr. B. M. Walter

VS DEC 3 - 1950

544 30

928

MEDICAL CERTIFICATION

810-1013

UNITED STATES OF AMERICA

NO. 1013

[Faint, illegible text covering the majority of the page, likely bleed-through from the reverse side.]

25
200

50-10314

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50-10314

BIRTH NO.

1. NAME OF DECEASED (Type or Print) CYRUS J. KUNSMAN (LEONARD F. McGE)		2. DATE OF DEATH November 30, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) A. STATE Maryland B. COUNTY 20-05	
B. FULL NAME OF HOSPITAL OR INSTITUTION University Hospital		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore	
D. LENGTH OF STAY IN BALTIMORE 24 Yrs. 24 Mths. 24 Days		D. STREET ADDRESS (If rural, give location) 2500 Block Delaney St	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Divorced	8. DATE OF BIRTH 7-28-1898
9. AGE (In years last birthday) 52		10. Under 1 Year Months: Days: Hours: Min.	11. Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist Rex		10B. KIND OF BUSINESS OR INDUSTRY R.R.	
11. BIRTHPLACE (State or foreign country) Dysart PENNA		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME Ella Mc Gee	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) YES		16. SOCIAL SECURITY NO. 2-9-17-10 7-7-19 2-9-01-2649	
17. INFORMANT Joseph J. Kunsman		ADDRESS 504 S. Longwood St	

18. **5400**

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)(A) **Purulent peritonitis**
DUE TO **ruptured gastric ulcer**

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	

22. I certify that I took charge of the remains described above, held an **Deep Inspection** thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: **natural causes** ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE Stanley A. Dunbar M.D.		23B. CHIEF MEDICAL EXAMINER..... <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER..... <input checked="" type="checkbox"/>		23C. DATE SIGNED Dec. 1, 1950	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/4/50		24C. NAME OF CEMETERY OR CREMATORY Balto V.S. National	
24D. LOCATION (City, town, or county) Balto Md		24E. STATE Md		25. FUNERAL DIRECTOR John G. S. M. Walters	
DATE RECEIVED BY LOCAL REGISTRAR DEC 3 - 1950		REGISTRAR'S SIGNATURE Wilmington Williams		25. FUNERAL DIRECTOR John G. S. M. Walters	

CERTIFICATE OF DEATH

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50-10315

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50-10315
Registered No.

BIRTH NO. ALVERIENA

1. NAME OF DECEASED
(Type or Print) ALBERTENA FEINOUR

2. DATE OF DEATH DEC. 1, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)
A. STATE MARYLAND B. COUNTY BaltimoreB. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR INSTITUTIONC. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
BALTIMORE

FRANCLIN SQUARE HOSPITAL.

D. STREET ADDRESS (If rural, give location)
4134 WILKENS AVE 5200C. Length of stay in Baltimore
Yrs. Mos. Days5. SEX
FEMALE6. COLOR OR RACE
WHITE7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)
WIDOWED8. DATE OF BIRTH
JANUARY 13, 18869. AGE (In years last birthday) 64
If Under 1 Year Months: Days If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY
HOUSEWIFE11. BIRTHPLACE (State or foreign country)
MARYLAND12. CITIZEN OF WHAT COUNTRY?
U.S.A.13. FATHER'S NAME
HERMAN PARROW14. MOTHER'S MAIDEN NAME
MARY ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS
Mrs Catherine Kane 2639 Frederick Ave

18. 332 X

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) CEREBRO MALACIA, LT. HEMISPHERE

3 wks

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) CEREBRAL THROMBOSIS

3 wks

DUE TO

(C) CEREBRAL ARTERIOSCLEROSIS

Not known

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

GENERALIZED ARTERIOSCLEROSIS

Not known

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) F INJURY

21E. INJURY OCCURRED WHILE AT ☐ WORK NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov. 9, 1950 to DEC 1, 1950 that I last saw the deceased alive on DEC 1, 1950, and that death occurred at 7:40 Am., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

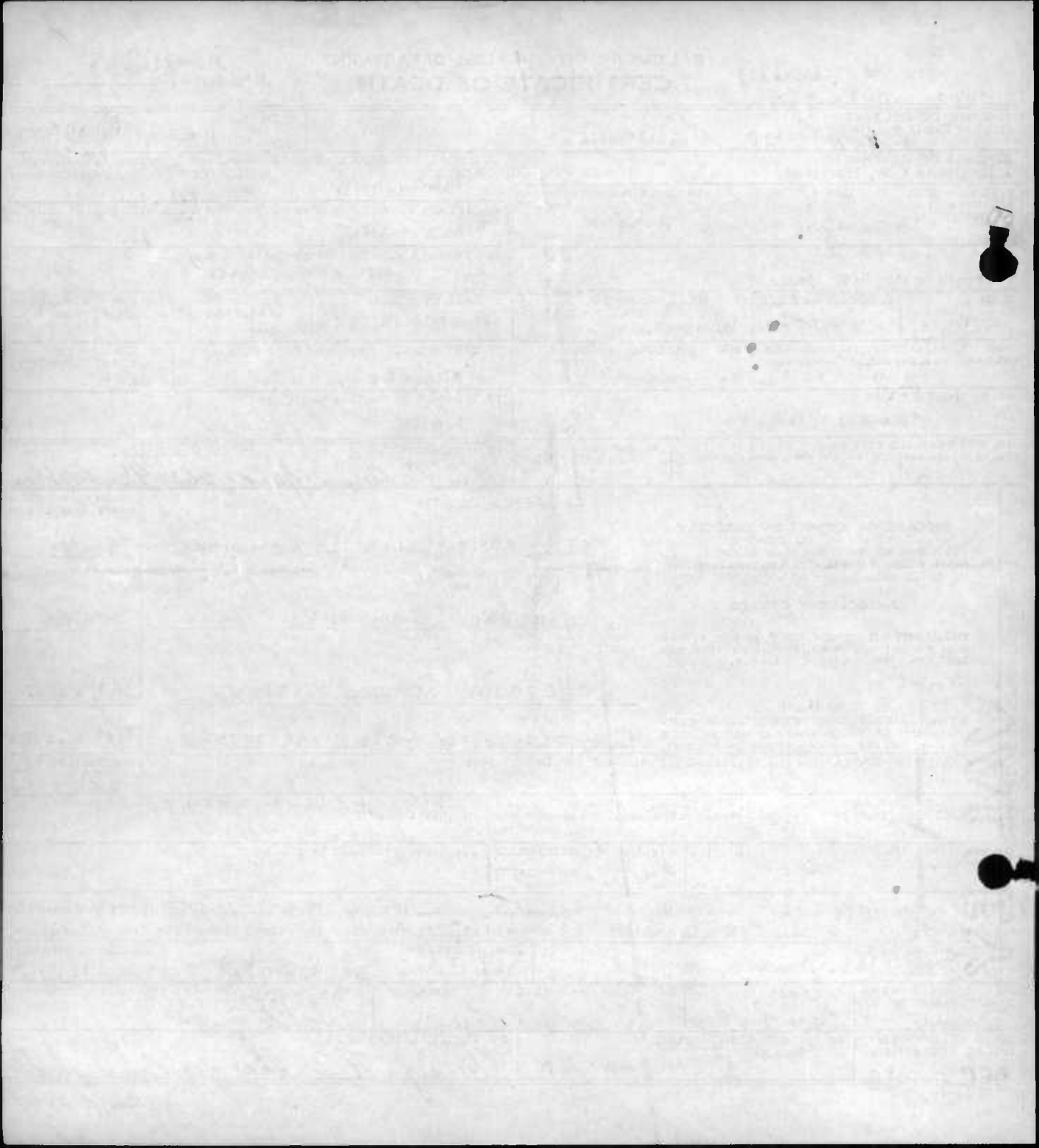
DEC 3-1950

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83 B

Balt 247

MEDICAL CERTIFICATION



- 250
50-10316

MIGAN
BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10316
Registered No.

1. NAME OF DECEASED (Type or Print) MIGAN, JAMES FRANCIS (JR.)			2. DATE OF DEATH 12-1-50		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 28-03		
5. FULL NAME OF HOSPITAL OR INSTITUTION UNION MEMORIAL HOSPITAL			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE		
6. Length of stay in Baltimore ?			D. STREET ADDRESS (If rural, give location) 1826 FOREST PARK Ave.		
5. SEX m	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH 8-3-1897	9. AGE (in years last birthday) 53	If Under 1 Year Months: Days If Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PACM SUPT.		10B. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME JAMES F. MIGAN, SR.		14. MOTHER'S MAIDEN NAME Catherine Ladogan	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) -		16. SOCIAL SECURITY NO. -		17. INFORMANT WIFE	
				ADDRESS (same)	

18. 540.0	CAUSE OF DEATH	INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)	(A) HEMORRHAGE FROM	
ANTECEDENT CAUSES	DUE TO	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B) GASTRIC ULCER	
	DUE TO	
	(C)	

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	RECENT INFARCTION, LEFT VENTRICLE	
---	--	--

19A. DATE OF OPERATION 2	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **NOV. 24, 1950**, to **DEC. 1, 1950**, that I last saw the deceased alive on **DEC. 1, 1950**, and that death occurred at **8:24 A. M.**, from the causes and on the date stated above.

23A. SIGNATURE Richard Beach	23B. ADDRESS Union Memorial Hospital	23C. DATE SIGNED 12-1-50
--	--	------------------------------------

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial	24B. DATE 12/4/50	24C. NAME OF CEMETERY OR CREMATORY Lorraine Pl.	24D. LOCATION (City, town, or county) (State) Woodlawn, Ind.
--	-----------------------------	---	--

DATE RECEIVED BY LOCAL REGISTRAR DEC 3 1950	REGISTRAR'S SIGNATURE Winston Williams, M.D.	25. FUNERAL DIRECTOR Harry H. Witzke	ADDRESS 4101 Edmondson
---	--	--	----------------------------------

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117a am

64-1-116

RECEIVED

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SAMA

50-10317

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

BIRTH NO. 50-26250

1. NAME OF DECEASED
(Type or Print)

Baby Girl Sama

2. DATE
OF
DEATH

Dec 2 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF
HOSPITAL OR
INSTITUTION

Mercy Hospital

C. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

Dec 2 1950

9. AGE (In years,
last birthday)If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.

2 35

10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

newborn

10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Alfred Sama

14. MOTHER'S MAIDEN NAME

Angelina Liberto

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

17. INFORMANT

Mother

ADDRESS

(as above)

18.

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

(A) Prolonged labor, and delivery
DUE TO Traumatic damage to the
Respiratory center & cerebrum

(B) Patient never breathed, was
Kept alive 2 hrs & 35 min by
Artificial Respiration

(C) Patient (4 lb 2 oz) with 157 form of twins

INTERVAL BETWEEN
ONSET AND DEATH2 hrs 35 min
from birth
to death

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e.g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12-2-50 3:45 PM, to 12-2-50 6:55 PM, 19__, that I last saw the
deceased alive on Dec 2, 1950, and that death occurred at 6:00 PM., from the causes and on the date stated above.

23A. SIGNATURE

Edward G. Hamberry

M. D.

23B. ADDRESS

Mercy Hospital

23C. DATE SIGNED

Dec 2 1950

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

BURIAL

24B. DATE

DEC 4 1950

24C. NAME OF CEMETERY OR CREMATORY

NEW CATHEDRAL CEM

24D. LOCATION (City, town, or county)

OLD FREDERICK RD MD

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

DEC 3 - 1950

Dippel Bros 1800 FLOMBARD ST

10-10-17

RECEIVED
FEDERAL BUREAU OF INVESTIGATION
U. S. DEPARTMENT OF JUSTICE

RECEIVED
FEDERAL BUREAU OF INVESTIGATION
U. S. DEPARTMENT OF JUSTICE

10 81301-05

50-10318

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED (Type or Print) <u>James M. Kemp</u>			2. DATE OF DEATH <u>12-2-50</u>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md.</u> COUNTY <u>Balto.</u>		
B. FULL NAME OF HOSPITAL OR INSTITUTION <u>Luthern Hospital</u>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <u>Dundalk</u>		
c. Length of stay in Baltimore <u>1 hr.</u>			D. STREET ADDRESS (If rural, give location) <u>2544 Liberty Pkwy. 5300</u>		
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Single</u>	8. DATE OF BIRTH <u>3/1/ 1902</u>		9. AGE (In years; last birthday) <u>48</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>machine operator</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Koppers Co.</u>	11. BIRTHPLACE (State or foreign country) <u>Frederick, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>James F. Kemp</u>			14. MOTHER'S MAIDEN NAME <u>Alice V. Schoff</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>no</u>		16. SOCIAL SECURITY NUMBER <u>212-091883</u>	17. INFORMANT ADDRESS <u>Miss. Lillian A. Kemp, Dundalk</u>		

18. <u>420.1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	CAUSE OF DEATH (A) <u>Myocardial Infarction</u> DUE TO (B) <u>Coronary Thrombosis</u> DUE TO (C) <u>Coronary atherosclerosis</u>	INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs</u> <u>yes</u>
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19A. DATE OF OPERATION <u>0</u>	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec. 2, 1950, to Dec. 2, 1950, that I last saw the deceased alive on Dec. 2, 1950, and that death occurred at 9:50 P.m., from the causes and on the date stated above.

23A. SIGNATURE <u>MNE Edwards</u>	M. D.	23B. ADDRESS <u>Luthern Hosp. of Md.</u>	23C. DATE SIGNED <u>12-2-50</u>
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24A. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>12/5/50</u>	24C. NAME OF CEMETERY OR CREMATORY <u>Loudon Park</u>	24D. LOCATION (City, town, or county) (State) <u>Balto., Md.</u>
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DATE RECEIVED BY LOCAL REGISTRAR <u>DEC 4 - 1950</u>	REGISTRAR'S SIGNATURE <u>Wilmington Williams, M.D.</u>	25. FUNERAL DIRECTOR <u>Walter Brooks Brodley, Dundalk, Md.</u>	ADDRESS
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81201-11

81201-11

CERTIFICATE OF DEATH

Name of Deceased		Date of Birth	
Sex		Race	
Place of Birth		Date of Death	
Cause of Death		Place of Death	
Signature of Physician		Signature of Registrar	
Date of Entry		Date of Filing	

264

10319

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10319

Registered No.

1. NAME OF DECEASED (Type or Print) <u>JAMES B. CASSERLY</u>			2. DATE OF DEATH <u>December 1, 1950</u>		
3. PLACE OF DEATH: A. Baltimore City, Maryland <u>Baltimore</u>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY _____		
B. FULL NAME OF (If not in hospital or institution, give street address or location) <u>St. Joseph's Hospital</u>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <u>Baltimore</u>		
C. Length of stay in Baltimore <u>59</u> Yrs. <u>78</u> Mos. <u>8</u> Days			D. STREET ADDRESS (If rural, give location) <u>1912 Homewood Ave.</u>		
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>4-23-1891</u>	9. AGE (In years last birthday) <u>59</u>	10. Under 1 Year Months: <u>8</u> Days: <u>23</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Inspector Sanitation Dept. Balto. City</u>			11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		
10B. KIND OF BUSINESS OR INDUSTRY			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>James Casserly</u>			14. MOTHER'S MAIDEN NAME <u>Ann Craig</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>yes</u> <u>world war 1</u>			16. SOCIAL SECURITY NO.		
17. INFORMANT <u>Mrs. Frederick A. Pick</u>			ADDRESS <u>3538 Greenmount</u>		

18. <u>E812.4</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>Fractured skull</u> <u>Intracranial hemorrhage</u> <u>Ruptured aorta</u> <u>Multiple fractures</u>		INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>street</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>North and Homewood Avenues</u>	
21D. TIME (Month) (Day) (Year) (Hour) <u>December 1, 1950 8 p. m.</u>		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>Pedestrian struck by auto</u>	
22. I certify that I took charge of the remains described above, held an <u>autopsy</u> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input checked="" type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .					
23A. SIGNATURE <u>William W. Conklin</u>		23B. CHIEF MEDICAL EXAMINER..... M.D. ASSISTANT MEDICAL EXAMINER..... MEDICAL INVESTIGATOR.....		23C. DATE SIGNED <u>Dec. 2, 1950</u>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12-5-1950</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Balto. Nat. Cemetery</u>	
24D. LOCATION (City, town, or county) <u>Baltimore, Md.</u>		25. FUNERAL DIRECTOR <u>Elmer W. Conklin</u>			
DATE RECEIVED BY LOCAL REGISTRAR <u>DEC 4 - 1950</u>		REGISTRAR'S SIGNATURE <u>Thurston Williams, Jr.</u>		ADDRESS <u>924 E. Eager St.</u>	

VS 151 N-804.2 210 93 170C

61871-00

RECEIVED

61871

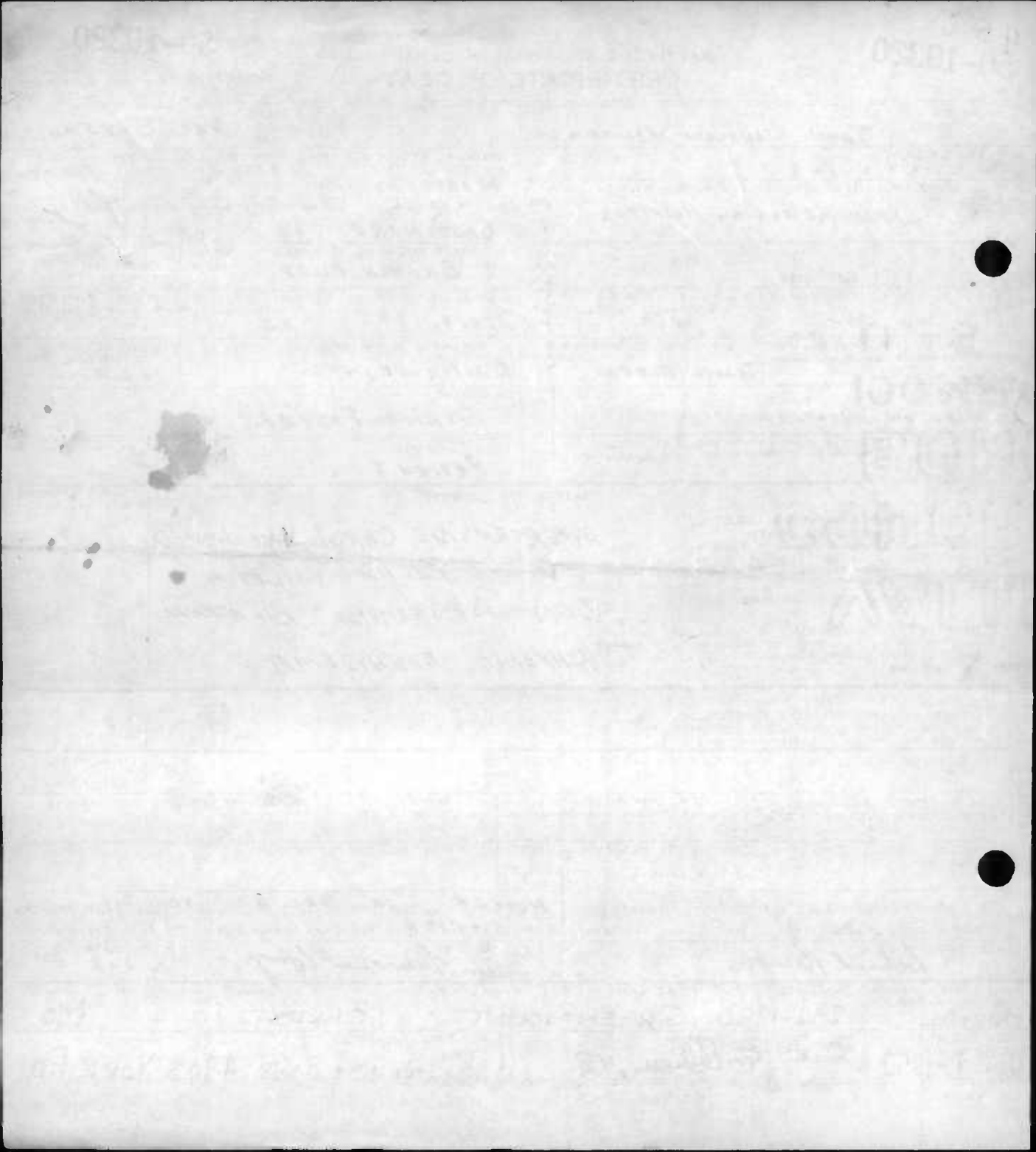
1. NAME OF PARTY	[Faint, illegible text]
2. ADDRESS	[Faint, illegible text]
3. CITY	[Faint, illegible text]

452
50-10320BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10320

Registered No. _____

BIRTH NO. _____		1. NAME OF DECEASED (Type or Print) JOHN WINSLOW WILLIAMS		2. DATE OF DEATH DEC. 2, 1950.	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY _____		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE 1 11-02	
5. FULL NAME OF DECEASED (If not in hospital or institution, give street address or location) UNION MEMORIAL HOSPITAL		6. STREET ADDRESS (If rural, give location) 8 BRANCH ALLEY		7. LENGTH OF STAY IN BALTIMORE Yrs. _____ Mos. _____ Days _____	
5. SEX M	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) W	8. DATE OF BIRTH DEC. 5, 1895	9. AGE (In years last birthday) 55	10. Under 1 Year Months: Days 11. Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TRAVEL AGENT		10B. KIND OF BUSINESS OR INDUSTRY TRAVEL BUREAU		11. BIRTHPLACE (State or foreign country) BALTIMORE, MD.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME WINSLOW WILLIAMS		14. MOTHER'S MAIDEN NAME ANNE FOSTER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. _____		17. INFORMANT PATIENT	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 443X I CAUSE OF DEATH (A) HYPERTENSIVE CARDIOVASCULAR DS. DUETO ACUTE PULMONARY EDEMA (B) BRONCHOPNEUMONIA, BILATERAL DUETO CHRONIC EMPHYSEMA (C) _____		INTERVAL BETWEEN ONSET AND DEATH ? ? ?			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONOITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY m. _____		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Nov. 27 , 19 50 , to DEC. 2 , 19 50 , that I last saw the deceased alive on Dec. 2 , 19 50 , and that death occurred at 1:35 P. M. , from the causes and on the date stated above.					
23A. SIGNATURE Richard Beach		23B. ADDRESS Union Memorial Hosp.		23C. DATE SIGNED 12-2-50	
24A. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 12-4-1950		24C. NAME OF CEMETERY OR CREMATORY GREENMOUNT	
24D. LOCATION (City, town, or county) (State) BALTO. MD.		24E. DATE RECEIVED BY LOCAL REGISTRAR DEC 4 - 1950		24F. REGISTRAR'S SIGNATURE Wilmington Williams, M.D.	
24G. FUNERAL DIRECTOR H.W. JENKINS & SONS		24H. ADDRESS 4905 YORK RD.			



536

-10321

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50-10321

1. NAME OF DECEASED (Type or Print) GRACE EMMA ANDERS		2. DATE OF DEATH Dec. 4-1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland 6014 Old Hayford Road		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE 6014 Old Hayford Road B. COUNTY Baltimore	
B. FULL NAME OF (If not in hospital or institution, give street address or hospital or institution) Hospital		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore Md.	
c. Length of stay in Baltimore 3 years		D. STREET ADDRESS (If rural, give location) Maryland	
5. SEX Female	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) widow	8. DATE OF BIRTH Sept. 5-1881
9. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10. B. KIND OF BUSINESS OR INDUSTRY at home	9. AGE (In years last birthday) 69 If Under 1 Year Months: Days If Under 24 Hours Hours: Min.
11. BIRTHPLACE (State or foreign country) Fredrick County, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Elias Brown		14. MOTHER'S MAIDEN NAME Catherine Phillips	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Wade H. Anders		ADDRESS 6014 Old Hayford	

18. 331X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Cerebral Hemorrhage	CAUSE OF DEATH (A) Cerebral Hemorrhage DUE TO	INTERVAL BETWEEN ONSET AND DEATH 1 week
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Arterio Sclerosis	(B) Arterio Sclerosis DUE TO	5 yrs
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION 0		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from **Nov 3**, 19**50**, to **Dec 4**, 19**50**, that I last saw the deceased alive on **Dec 2**, 19**50**, and that death occurred at **1:50 A.** m., from the causes and on the date stated above.

23A. SIGNATURE E. Gill Hall MD	23B. ADDRESS 1631 E North Ave	23C. DATE SIGNED 12/4/50
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24A. BURIAL, CREMATION, REMOVAL (Specify) Burial	24B. DATE Dec. 6-50	24C. NAME OF CEMETERY OR CREMATORY Wm. Tabor Cem.	24D. LOCATION (City, town, or county) (State) Backs Ridge, Md
DATE RECEIVED BY LOCAL REGISTRAR DEC 4 - 1950		REGISTRAR'S SIGNATURE Thurston Williams, MD	25. FUNERAL DIRECTOR Powell & Hartzler Woodolow & Liberty Town, Md. 83a

1931-50

UNITED STATES DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

1931-50

1. Name of deceased		2. Sex		3. Age		4. Date of death	
5. Place of death		6. Cause of death		7. Manner of death		8. Signature of physician	
9. Signature of registrar		10. Signature of informant		11. Signature of witness		12. Signature of funeral director	
13. Signature of undertaker		14. Signature of cemetery		15. Signature of burial place		16. Signature of interment	
17. Signature of burial place		18. Signature of interment		19. Signature of burial place		20. Signature of interment	
21. Signature of burial place		22. Signature of interment		23. Signature of burial place		24. Signature of interment	
25. Signature of burial place		26. Signature of interment		27. Signature of burial place		28. Signature of interment	
29. Signature of burial place		30. Signature of interment		31. Signature of burial place		32. Signature of interment	
33. Signature of burial place		34. Signature of interment		35. Signature of burial place		36. Signature of interment	
37. Signature of burial place		38. Signature of interment		39. Signature of burial place		40. Signature of interment	
41. Signature of burial place		42. Signature of interment		43. Signature of burial place		44. Signature of interment	
45. Signature of burial place		46. Signature of interment		47. Signature of burial place		48. Signature of interment	
49. Signature of burial place		50. Signature of interment		51. Signature of burial place		52. Signature of interment	
53. Signature of burial place		54. Signature of interment		55. Signature of burial place		56. Signature of interment	
57. Signature of burial place		58. Signature of interment		59. Signature of burial place		60. Signature of interment	
61. Signature of burial place		62. Signature of interment		63. Signature of burial place		64. Signature of interment	
65. Signature of burial place		66. Signature of interment		67. Signature of burial place		68. Signature of interment	
69. Signature of burial place		70. Signature of interment		71. Signature of burial place		72. Signature of interment	
73. Signature of burial place		74. Signature of interment		75. Signature of burial place		76. Signature of interment	
77. Signature of burial place		78. Signature of interment		79. Signature of burial place		80. Signature of interment	
81. Signature of burial place		82. Signature of interment		83. Signature of burial place		84. Signature of interment	
85. Signature of burial place		86. Signature of interment		87. Signature of burial place		88. Signature of interment	
89. Signature of burial place		90. Signature of interment		91. Signature of burial place		92. Signature of interment	
93. Signature of burial place		94. Signature of interment		95. Signature of burial place		96. Signature of interment	
97. Signature of burial place		98. Signature of interment		99. Signature of burial place		100. Signature of interment	

530
50-10322BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50-10322
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <i>LOUISE JEANNETTE Smith</i>		2. DATE OF DEATH <i>12/3/50</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland - <i>St Joseph's Hosp.</i>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MARYLAND</i> B. COUNTY <i>16-05</i>	
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>St. Joseph's Hospital</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>BALTIMORE</i>	
C. Length of stay in Baltimore <i>50 yrs</i>		D. STREET ADDRESS (If rural, give location) <i>2322 ARUNAH AVE - #16</i>	
5. SEX <i>FEM.</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Sep.</i>	8. DATE OF BIRTH <i>10/3/00</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Operator -</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Madbeer Sheet Co. (M)</i>	9. AGE (In years last birthday) <i>50</i>
11. BIRTHPLACE (State or foreign country) <i>BALTIMORE</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>LORENZ RAUSCH</i>		14. MOTHER'S MAIDEN NAME <i>Annie Snyder</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>NO</i>		16. SOCIAL SECURITY NO. <i>213-16-5290</i>	
17. INFORMANT <i>SON.</i>		ADDRESS <i>same</i>	
18. <i>416 X</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) <i>CONGESTIVE HEART FAILURE</i> DUE TO (B) <i>RHEUMATIC HEART DISEASE</i> DUE TO (C) _____ INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION <i>0</i>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>11-14</i> , 19 <i>50</i> to <i>12-3</i> , 19 <i>50</i> , that I last saw the deceased alive on <i>12-3</i> , 19 <i>50</i> , and that death occurred at <i>9:30 p.</i> m., from the causes and on the date stated above.			
23A. SIGNATURE <i>E. Paul Coffey Jr.</i>		23B. ADDRESS <i>St Joseph's Hospital</i>	
23C. DATE SIGNED <i>12-3-50</i>			
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>12-7-50</i>	
24C. NAME OF CEMETERY OR CREMATORY <i>Meadowridge Memorial</i>		24D. LOCATION (City, town, or county) (State) <i>Howard County Md.</i>	
DATE RECEIVED BY LOCAL REGISTRAR <i>DEC 4 - 1950</i>		REGISTRAR'S SIGNATURE <i>Huntington Williams, M.D.</i>	
25. FUNERAL DIRECTOR <i>George L. Schwab</i>		ADDRESS <i>2101 Frederick Ave.</i>	

10-10-52

RECEIVED BY THE
BUREAU OF THE
FEDERAL BUREAU OF INVESTIGATION

10-10-52

10-10-52



Primary site: "Possibly ovary"

See Document File 50-10323

12/21/50 ES

524

50-10324

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10324

Registered No.

1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH	
Josephine Anzalone		Dec. 1-1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION 7121 Harford Rd.		C. CITY OR TOWN Baltimore	
c. Length of stay in Baltimore Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) 7121 Harford Road	
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Oct. 16-1883
9A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home		9B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 67
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Italy
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME Francisco Gro	
14. MOTHER'S MAIDEN NAME Paula		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	
16. SOCIAL SECURITY NO.		17. INFORMANT Mr. Salvatore Anzalone	
18. 331X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Cerebral Hemorrhage		INTERVAL BETWEEN ONSET AND DEATH 12 hrs	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Arteriosclerosis with hypertension		15 yrs?	
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
21. DATE OF OPERATION		22. MAJOR FINDINGS OF OPERATION	
23. ACCIDENT, SUICIDE, HOMICIDE (Specify)		24. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	
25. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		26. TIME (Month) (Day) (Year) (Hour) OF INJURY	
27. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		28. HOW DID INJURY OCCUR?	
29. I hereby certify that I attended the deceased from Nov 17, 1948, to Dec 1, 1950, that I last saw the deceased alive on Dec 1, 1950, and that death occurred at 3:15 A.M., from the causes and on the date stated above.			
30. SIGNATURE E. J. Luck		31. ADDRESS 6217 Harford Rd	
32. DATE SIGNED Dec. 1, 1950		33. DATE SIGNED	
34. BURIAL, CREMATION, REMOVAL (Specify) Burial		35. DATE 12/4/50	
36. NAME OF CEMETERY OR CREMATORY Holy Redeemer		37. LOCATION (City, town, or county) (State) Baltimore Md	
38. DATE RECEIVED BY LOCAL REGISTRAR DEC 4-1950		39. REGISTRAR'S SIGNATURE E. J. Luck	
40. FUNERAL DIRECTOR E. J. Luck		41. ADDRESS 5305 Harford Rd	

MEDICAL CERTIFICATION

Dr. J. J. J. J.

630
50-10325

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10325

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Madelin M. GARRETT		2. DATE OF DEATH 12/1/50	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MARYLAND B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION MERCY Hosp		C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township) BALTIMORE 8-01	
c. Length of stay in Baltimore LIFE		D. STREET ADDRESS (If rural, give location) 2802 CLIFTON PARK TERRACE	
5. SEX F	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Auditor - U.S. Customs House		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME CONRAD MINDERLEIN		14. MOTHER'S MAIDEN NAME VERONICA MINDERLEIN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.	
		17. INFORMANT Mrs. Harry Franz Jr. ADDRESS 2802 Clifton Plk	

18. 180X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) CARCINOMA OF KIDNEY	CAUSE OF DEATH (A) CARCINOMA OF KIDNEY DUE TO GENERALIZED METASTASIS (B) GENERALIZED METASTASIS DUE TO (C)	INTERVAL BETWEEN ONSET AND DEATH 4 YRS
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION, LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION 0	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED m. WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **12/1**, 19**50**, to **12/1**, 19**50**, that I last saw the deceased alive on **12/1**, 19**50**, and that death occurred at **11:40 P.M.**, from the causes and on the date stated above.

23A. SIGNATURE Oliver R. Root	23B. ADDRESS Mercy Hosp	23C. DATE SIGNED 11/2/50
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24A. BURIAL, CREMATION, REMOVAL (Specify) Burial	24B. DATE 12/5/50	24C. NAME OF CEMETERY OR CREMATORY New Cathedral	24D. LOCATION (City, town, or county) (State) Baltimore Md.
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DATE RECEIVED BY LOCAL REGISTRAR DEC 4 - 1950	REGISTRAR'S SIGNATURE Wm. L. Luck	25. FUNERAL DIRECTOR L. J. Luck	ADDRESS 5305 Harford Rd.
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262
50-10326BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10326

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION THE JOHNS HOPKINS HOSPITAL

c. Length of stay in Baltimore

5. SEX

male

6. COLOR OR RACE

white

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR
INDUSTRY

13. FATHER'S NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.2. DATE
OF
DEATH Dec 3, 1950
4. USUAL RESIDENCE (Where deceased lived. If institution, residence
before admission)
A. STATE S. Carolina B. COUNTY V-20C. CITY OR TOWN (If outside corporate limits, write RURAL and give
township)
HartsvilleD. STREET ADDRESS (If rural, give location)
Route 2

B. DATE OF BIRTH

10-3-50

9. AGE (in years
last birthday)

23

If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.

11. BIRTHPLACE (State or foreign country)

S. Carolina

12. CITIZEN OF
WHAT COUNTRY?

14. MOTHER'S MAIDEN NAME

Emily Fitchett

17. INFORMANT

ADDRESS

THE JOHNS HOPKINS HOSPITAL

18. 754.6 I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)(A) Congenital Heart Disease -
DUE TO Cystotic Type.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) Transposition of The Great Vessels
DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY21E. INJURY OCCURRED
WHILE AT ☐ NOT WHILE
WORK AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11/16, 1950, to 12/3, 1950 that I last saw the
deceased alive on 12/3, 1950, and that death occurred at 2 P.m., from the causes and on the date stated above.

23A. SIGNATURE

Carl Swan Smith

M. D.

23B. ADDRESS

THE JOHNS HOPKINS HOSPITAL

23C. DATE SIGNED

Dec. 3, 1950

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

Dec. 5-1950

24C. NAME OF CEMETERY OR CREMATORY

Magnolia

24D. LOCATION (City, town, or county)

Hartsville S. Carolina

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Tunstington Williams, Jr.

25. FUNERAL DIRECTOR

H. Sanders, Sons, Inc.
Baltimore, Md. 157E

DEC 4-1950

VS-150

Med. Ex Case To be approved

RELEASED TO HOSPITAL

NOT A MEDICAL EXAMINER'S CASE

William H. Smith M.D.
CHIEF OR ASST. MEDICAL EXAMINER

**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

50-10327
Registered No.

350
50-10327

BIRTH NO.

1. NAME OF DECEASED (Type or Print) JEFFERSON DAVID ROTEN <i>ROTEN, JEFFERSON D.</i>			2. DATE OF DEATH 2 DEC. 1950		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MD. B. COUNTY		
B. FULL NAME OF HOSPITAL OR INSTITUTION LUTHERON HOSP. OF MD.			C. CITY OR TOWN BALTO.		
C. Length of stay in Baltimore Life			D. STREET ADDRESS (If rural, give location) 1816 RUTLAND AVE.		
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 6-3-65		9. AGE (In years last birthday) 82
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Penna. R.R. Locomotive Engineer. Ret. 14 yrs			11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME David Roten			14. MOTHER'S MAIDEN NAME Not Known		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Robert O. Roten (son) 3707 Keswick Rd.	

MEDICAL CERTIFICATION

18. 153X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CARCINOMA OF COLON CARDIAC FAILURE		INTERVAL BETWEEN ONSET AND DEATH
(A) DUE TO		
(B) Cor. DUE TO		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. CORONARY ARTERIOSCLEROSIS		
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		
19A. DATE OF OPERATION 18 Nov. 1950	19B. MAJOR FINDINGS OF OPERATION CARCINOMA, ASCENDING COLON	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from 12 Nov. , 1950, to 2 DEC. , 1950, that I last saw the deceased alive on 2 DEC. , 1950, and that death occurred at 2 P. m., from the causes and on the date stated above.		
23A. SIGNATURE <i>James P. Hare</i>	23B. ADDRESS <i>Lutheron Hosp.</i>	23C. DATE SIGNED 2 DEC 50
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial	24B. DATE Dec. 1950	24C. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery
24D. LOCATION (City, town, or county) Baltimore Md		(State)
DATE RECEIVED BY LOCAL REGISTRAR DEC 4-1950	REGISTRAR'S SIGNATURE <i>Wilmington Williams</i>	25. FUNERAL DIRECTOR HENRY SANDER & SONS, INC. Baltimore Md.
		ADDRESS <i>Henry P. Sander</i>

100-10000

CERTIFICATE OF DEATH

100-10000



632
50-10328

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10328
Registered No.

1. NAME OF DECEASED (Type or Print) KEZIE MAY KRATZ <i>Kratz, Keza Mae</i>		2. DATE OF DEATH Dec 1, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland <i>Women's Hospital</i>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Balto City</i>	
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>Women's Hospital</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore</i> 12-07	
C. Length of stay in Baltimore ? <i>45 yrs</i>		D. STREET ADDRESS (If rural, give location) <i>2644 Maryland Ave</i>	
5. SEX F	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Widowed</i>	8. DATE OF BIRTH Oct 20, 1879
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife, W.</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>H. W.</i>	9. AGE (in years last birthday) 71
13. FATHER'S NAME <i>John Moore</i>		11. BIRTHPLACE (State or foreign country) <i>Sharpsburg, Md</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		12. CITIZEN OF WHAT COUNTRY? <i>U. S.</i>	
16. SOCIAL SECURITY NO. -		14. MOTHER'S MAIDEN NAME <i>Elizabeth Brashears</i>	
17. INFORMANT <i>self</i>		ADDRESS	

18. 153X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH <i>ascending</i> (A) Carcinoma colon DUE TO <i>with metastases</i> (B) _____ DUE TO _____ (C) _____ INTERVAL BETWEEN ONSET AND DEATH ?	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) _____ DUE TO _____ (C) _____	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	

19A. DATE OF OPERATION Oct 10, 1950		19B. MAJOR FINDINGS OF OPERATION <i>Destructive carcinoma ascending colon: metastases</i>		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDER- Lying <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>Sept 28</i> 1950, to <i>Dec 1</i> 1950, that I last saw the deceased alive on <i>Dec 1</i> 1950, and that death occurred at <i>11 P</i> m., from the causes and on the date stated above.					
23A. SIGNATURE <i>E. T. Bennett M.D.</i>		23B. ADDRESS <i>Women's Hosp</i>		23C. DATE SIGNED <i>12/1/50</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE Dec. 5. 1950		24C. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery	
DATE RECEIVED BY LOCAL REGISTRAR DEC 4-1950		REGISTRAR'S SIGNATURE <i>Wilmington Williams, M.D.</i>		25. FUNERAL DIRECTOR & ADDRESS HENRY SANDER & SONS, INC. <i>Baltimore Md.</i>	

IT 2-8
FINDING
BOMBS
COM STAFF
ANALYST

235

50-10329
BIRTH NO.BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50-10329
Registered No.

1. NAME OF DECEASED (Type or Print) EDWARD LOUIS KOSTENS		2. DATE OF DEATH Dec. 2, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. Maryland B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION Union Memorial Hosp. D.O.A.		C. CITY OR TOWN (If outside corporate limits, write full name and give township) Baltimore	
c. Length of stay in Baltimore Yrs. _____ Mos. _____ Days _____		D. STREET ADDRESS (If rural, give location) 3203 N. Charles Street	
5. SEX M	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) single	8. DATE OF BIRTH Mar. 21, 1905
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Accountant		10B. KIND OF BUSINESS OR INDUSTRY New Amsterdam CASUALTY CO.	9. AGE (in years last birthday) 45
11. BIRTHPLACE (State or foreign country) Annapolis Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Louis Kostens		14. MOTHER'S MAIDEN NAME Lena Herzog	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) yes		16. SOCIAL SECURITY NO. 212-10-1458	
17. INFORMANT 204 N. Linwood Ave.		ADDRESS Mrs. Louis Kostens (mother)	

18. 4201 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Coronary Artery Disease	CAUSE OF DEATH Coronary Artery Disease	INTERVAL BETWEEN ONSET AND DEATH 4 years
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(A) DUE TO	
(B) DUE TO		
(C) DUE TO		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

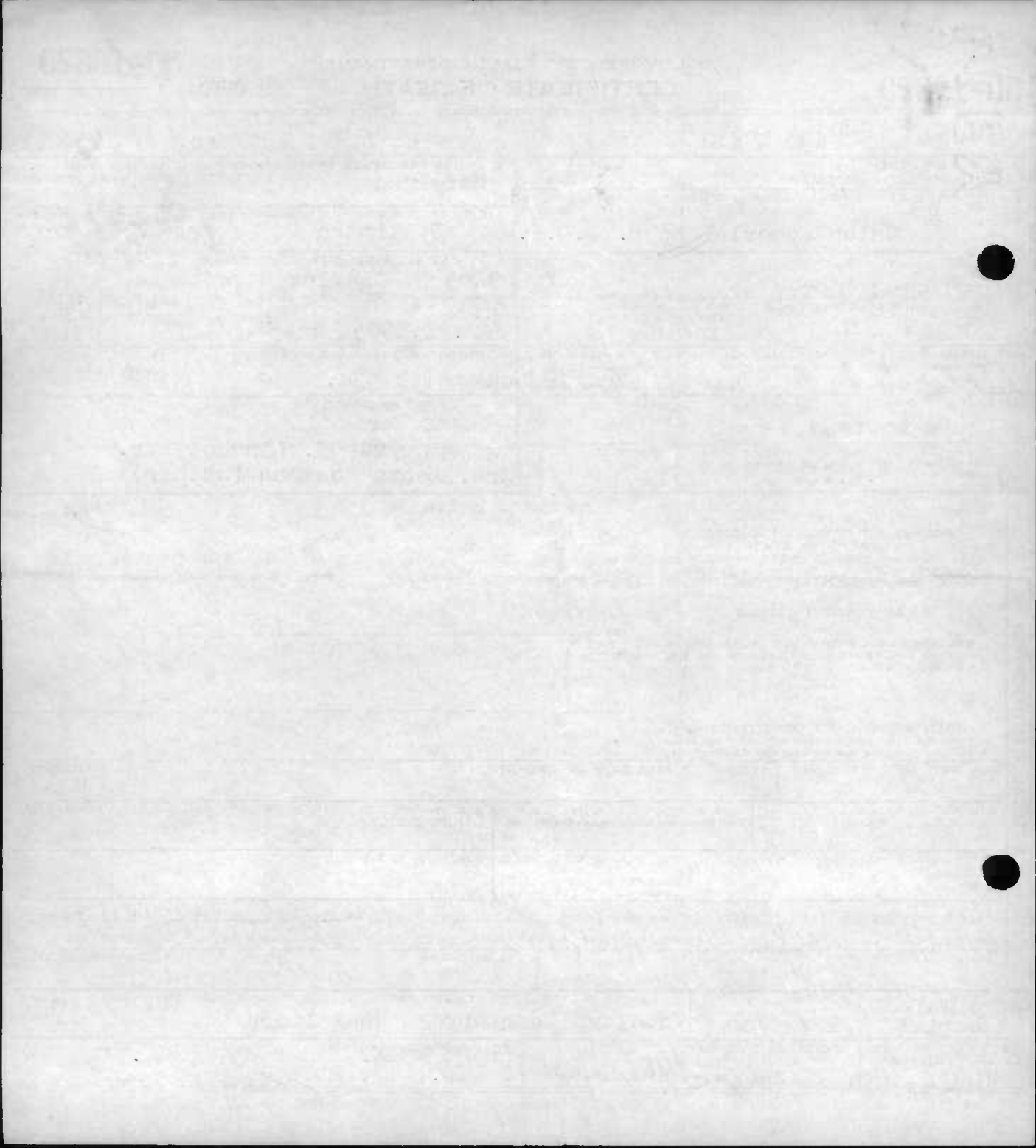
19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from Oct. 1946 to Dec. 2, 1950 , that I last saw the deceased alive on 12/1 , 19 50 , and that death occurred at 8:30 A.M. , from the causes and on the date stated above.		
23A. SIGNATURE John P. [Signature]	23B. ADDRESS M.D.	23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify) burial	24B. DATE 12/ /50	24C. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery	24D. LOCATION (City, town, or county) (State) Baltimore Md.
DATE RECEIVED BY LOCAL REGISTRAR DEC 4-1950		REGISTRAR'S SIGNATURE Wilmington Williams, M.D.	
VS 150		FUNERAL DIRECTOR HENRY SANDER & SONS, INC BALTO., 13, MD.	

000 73

940

MEDICAL CERTIFICATION



200
50-10330
BIRTH NO.BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50-10330

1. NAME OF DECEASED (Type or Print) <i>Charles F. Husey</i>		2. DATE OF DEATH <i>12/2/50</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <i>1707 Forest Park Ave</i>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>MD</i> B. COUNTY <i>2803</i>	
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>1707 Forest Park Ave</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>1707 Forest Park Ave</i>	
Length of stay in Baltimore <i>7044</i> Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) <i>1707 Forest Park Ave</i>	
5. SEX <i>17</i>	6. COLOR OR RACE <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>married</i>	8. DATE OF BIRTH <i>May 31-1880</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Janitor</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Balt. Teamsters Co.</i>	9. AGE (In years last birthday) <i>70</i>
11. BIRTHPLACE (State or foreign country) <i>Baltimore Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>US</i>	
13. FATHER'S NAME <i>Rudolph Husey</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>213-10-0141</i>	
17. INFORMANT <i>Mrs. Josephine M. Husey</i>		17A. ADDRESS <i>1707 Forest Park Ave</i>	
18. <i>470.1</i> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <i>CORONARY DISEASE</i> DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. HOW DID INJURY OCCUR?	
21E. TIME (Month) (Day) (Year) (Hour) OF INJURY		21F. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22. I certify that I took charge of the remains described above, held an <i>Inspection</i> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> accident <input type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/> .			
23A. SIGNATURE <i>Phyllis B. B. B.</i>		23B. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> MEDICAL INVESTIGATOR <input type="checkbox"/>	
23C. DATE SIGNED <i>12/2/50</i>			
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>12-6-50</i>	
24C. NAME OF CEMETERY OR CREMATORY <i>Salem Park Cem</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore Md</i>	
DATE RECEIVED BY LOCAL REGISTRAR <i>DEC 4-1950</i>		REGISTRAR'S SIGNATURE <i>Wilmington Williams, M.D.</i>	
25. FUNERAL DIRECTOR <i>Les E. Beyer Jr</i>		ADDRESS <i>1512 Hollins St</i>	

**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

50-10331
Registered No.

264
50-10331
BIRTH NO.

1. NAME OF DECEASED (Type or Print) <i>Le Roy Edward Mc Carley</i>			2. DATE OF DEATH <i>12-2-50</i>		
3. PLACE OF DEATH: A. Baltimore City, Maryland <i>202 S. Bruce St</i>			4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i>		
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION			C. CITY OR TOWN (If outside corporate limits, write R.U.I. and give township) <i>Baltimore</i>		
C. Length of stay in Baltimore <i>50 years</i>			D. STREET ADDRESS (If rural, give location) <i>202 S. Bruce St</i>		
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Married</i>	8. DATE OF BIRTH <i>Feb. 19-1900</i>		9. AGE (In years last birthday) <i>50</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Produce Dealer</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Produce (R)</i>	11. BIRTHPLACE (State or foreign country) <i>Baltimore Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>
13. FATHER'S NAME <i>Edward E. Mc Carley</i>			14. MOTHER'S MAIDEN NAME <i>Emma E. Benny</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>214-20-7864</i>	17. INFORMANT ADDRESS <i>Maria M. Mc Carley 202 S Bruce St</i>		

18. <i>420.1</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	CAUSE OF DEATH (A) <i>Coronary Heart Disease</i> DUE TO (B) _____ DUE TO (C) _____	INTERVAL BETWEEN ONSET AND DEATH <i>Months</i>
--	---	---

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE <input type="checkbox"/> WORK AT WORK	21F. HOW DID INJURY OCCUR?		
22. I certify that I took charge of the remains described above, held an <i>Inspection</i> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> accident <input type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/> .				
23A. SIGNATURE <i>Robert R. Mc Carley</i>		23B. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> MEDICAL INVESTIGATOR <input checked="" type="checkbox"/> <i>12-2-50</i>		

24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>12-6-50</i>	24C. NAME OF CEMETERY OR CREMATORY <i>Londown Park</i>	24D. LOCATION (City, town, or county) (State) <i>Baltimore Md</i>
DATE RECEIVED BY LOCAL REGISTRAR <i>DEC 4-1950</i>		REGISTRAR'S SIGNATURE <i>Timothy Williams, M.D.</i>	25. FUNERAL DIRECTOR ADDRESS <i>Geo. R. Beyer Jr 1512 Hollins St</i>

VS 151

MEDICAL CERTIFICATION

10-1-1931

RECEIVED AT THE
CENTRAL OFFICE OF THE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D. C.

10-1-1931



356
50-10332

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50-10332

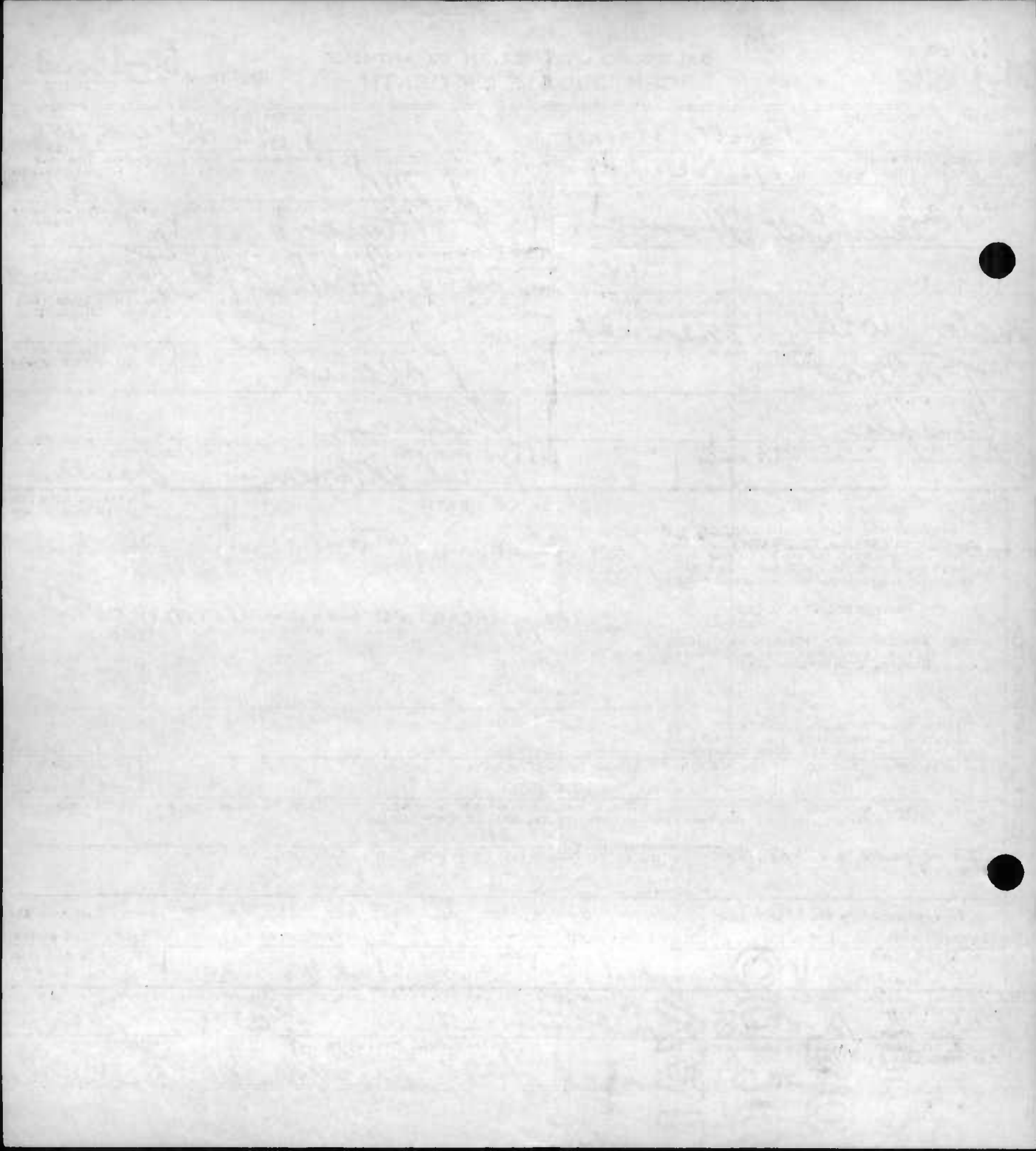
1. NAME OF DECEASED (Type or Print) <i>Israel Steiner</i>		2. DATE OF DEATH <i>Dec 3, 1950</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <i>1701 Ellamant St.</i>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md</i> B. COUNTY <i>Baltimore</i>	
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>Leubblatt Home</i>		C. CITY OR TOWN (If outside corporate limits, write full name and give township) <i>Baltimore 15-13</i>	
C. Length of stay in Baltimore <i>44</i> Yrs. <i>44</i> Mos. <i>44</i> Days		D. STREET ADDRESS (If rural, give location) <i>2538 Park Heights Terrace</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>married</i>	8. DATE OF BIRTH
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Tailor (prop.)</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>(R)</i>	
11. BIRTH PLACE (State or foreign country) <i>Poland</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Joseph</i>		14. MOTHER'S MAIDEN NAME <i>Shanall</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Sarah Steiner</i>		ADDRESS <i>same</i>	

18. <i>4201</i> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) <i>Coronary Thrombosis</i> DUE TO		INTERVAL BETWEEN ONSET AND DEATH <i>1 min.</i>	
II ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) <i>Hypertensive Cardio. Vasc. Dis.</i> DUE TO			
(C)			
19A. DATE OF OPERATION <i>0</i>		19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from *Jan 1, 1950*, to *Dec 3, 1950*, that I last saw the deceased alive on *Dec 3, 1950*, and that death occurred at *1:15 P.M.* from the causes and on the date stated above.

23A. SIGNATURE *Samuel V. Vongahen* M. O. *3600 Paul Ave* 23B. ADDRESS *1015* 23C. DATE SIGNED *Dec 3, 1950*

24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>12-4-50</i>	24C. NAME OF CEMETERY OR CREMATORY <i>Rosedale</i>	24D. LOCATION (City, town, or county) (State) <i>Balto Md</i>
DATE RECEIVED BY LOCAL REGISTRAR <i>DEC 4 1950</i>		REGISTRAR'S SIGNATURE <i>Antington Williams, M.D.</i>	25. FUNERAL DIRECTOR <i>Jack Lewis Inc</i> ADDRESS <i>2100 Centurk</i>



455
50-10333BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50-10333

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <i>Bessie Faye Schulman</i>			2. DATE OF DEATH <i>2 Dec. '50</i>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md</i> B. COUNTY		
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>3746 Columbus Drive</i>			C. CITY OR TOWN (If outside corporate limits, write BURIAL, and give township) <i>Baltimore 15-11</i>		
D. STREET ADDRESS (If rural, give location) <i>Life</i> <i>3746 Columbus Drive</i>			E. DATE OF BIRTH		
F. LENGTH OF STAY IN BALTIMORE			G. AGE (in years, months, days) <i>50</i>		
H. SEX <i>Female</i>			I. COLOR OR RACE <i>White</i>		
J. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Married</i>			K. DATE OF BIRTH		
L. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired) <i>Housewife</i>			M. BIRTHPLACE (State or foreign country) <i>Balto Md</i>		
N. KIND OF BUSINESS OR INDUSTRY			O. CITIZEN OF WHAT COUNTRY?		
P. FATHER'S NAME <i>Max Kleasman</i>			Q. MOTHER'S MAIDEN NAME <i>Lesue</i>		
R. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)			S. SOCIAL SECURITY NO.		
T. INFORMANT <i>William Schulman - Son</i>			U. ADDRESS		

18. <i>170 x 1</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) <i>Carcinoma of breast, Left.</i> DUE TO (B) DUE TO (C) INTERVAL BETWEEN ONSET AND DEATH <i>12 yrs.</i>	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (A) DUE TO (B) DUE TO (C) OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	

19A. DATE OF OPERATION <i>12-19-50</i>		19B. MAJOR FINDINGS OF OPERATION <i>Carcinoma of Breast with Metastasis</i>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from <i>18 June, 1950</i> , to <i>2 Dec., 1950</i> , that I last saw the deceased alive on <i>1 Dec., 1950</i> , and that death occurred at <i>6:30 p.m.</i> , from the causes and on the date stated above.		23A. SIGNATURE <i>G. Schumacher</i>		23B. ADDRESS <i>5829 Park Hts. Ave</i>		23C. DATE SIGNED <i>2 Dec. '50</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>12-4-50</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Heavening Run</i>		24D. LOCATION (City, town, or county) (State) <i>Balto Md</i>	
25. FUNERAL DIRECTOR <i>Jack Lewis & Co</i>		25. ADDRESS <i>2100 Eutan Pl</i>		25. SIGNATURE <i>William Williams, M.D.</i>		25. DATE <i>DEC 4 - 1950</i>	

1992

640
50-10334BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10334

Registered No.

1. NAME OF DECEASED (Type or Print) ALOYSIUS WILLIAM CARROLL		2. DATE OF DEATH DEC 3, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland Baltimore		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE	
B. FULL NAME OF HOSPITAL OR INSTITUTION U.S. MARINE HOSPITAL		C. CITY OR TOWN (If outside corporate limits, write R.U. and give township) BALTIMORE	
c. Length of stay in Baltimore 30		D. STREET ADDRESS (If rural, give location) 507 E. 30th ST.	
5. SEX M	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) SINGLE	8. DATE OF BIRTH AUG. 19, 1903
9. AGE (In years last birthday) 47		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME TIMOTHY CARROLL		14. MOTHER'S MAIDEN NAME ELIZABETH FRENCH	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) YES WORLD WAR II		16. SOCIAL SECURITY NO. 218032616	
17. INFORMANT LOUISE CARROLL		ADDRESS 507 E. 30th ST. BALTIMORE	
18. DOY X I CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) TUBERCULOSIS OF LUNGS, FAR ADVANCED DUE TO INTERVAL BETWEEN ONSET AND DEATH P ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. (C)			
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
22. TIME (Month) (Day) (Year) (Hour) OF INJURY	22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	22F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from DEC. 2 , 19 50 , to DEC. 3 , 19 50 , that I last saw the deceased alive on DEC 2 , 19 50 , and that death occurred at 8 A. M. , from the causes and on the date stated above.			
23A. SIGNATURE Richard A. Saavedra		23B. ADDRESS U.S. MARINE HOSPITAL	
23C. DATE SIGNED DEC 3 1950			
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial	24B. DATE 12-7-1950	24C. NAME OF CEMETERY OR CREMATORY St. John's	24D. LOCATION (City, town, or county) (State) Long Green Md.
DATE RECEIVED BY LOCAL REGISTRAR DEC 4 1950	REGISTRAR'S SIGNATURE Wilmington Williams, M.D.	25. FUNERAL DIRECTOR John A. Moran	
		ADDRESS 3000 E. Baltimore St.	

1350431

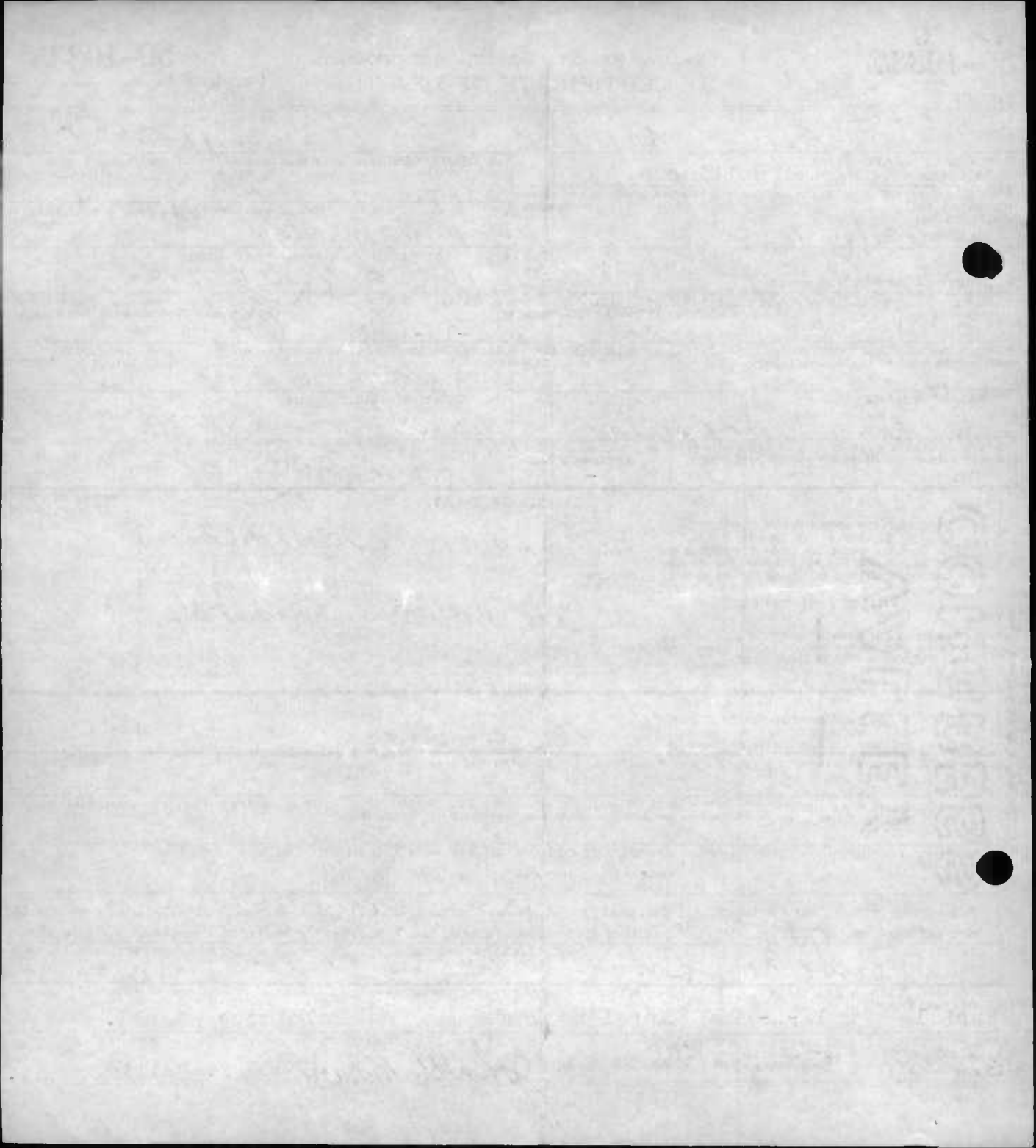
UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION

100-100000

[Faint, mostly illegible text covering the body of the document, possibly a letter or report. Some words like "TO:", "FROM:", and "SUBJECT:" are faintly visible.]

460
50-10335BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50-10335
Registered No.

BIRTH NO.		1. NAME OF DECEASED (Type or Print) ALICE MILLER		2. DATE OF DEATH 12-2-50	
3. PLACE OF DEATH: A. Baltimore City, Maryland Baltimore		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY 2			
B. FULL NAME OF HOSPITAL OR INSTITUTION UNIV. HOSP.		C. CITY OR TOWN (If outside corporate limits, write FULL and give township) BALTIMORE 9-08			
C. Length of stay in Baltimore — life		D. STREET ADDRESS (If rural, give location) 1026 E NORTH AVE.			
5. SEX F	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH 6-13-1886	9. AGE (in years last birthday) 64
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H. W.		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MD.	
13. FATHER'S NAME ALICE W. WENTWORTH		14. MOTHER'S MAIDEN NAME BARBARA ERMANN		12. CITIZEN OF WHAT COUNTRY? US	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no		16. SOCIAL SECURITY NO. —		17. INFORMANT ADDRESS HOSP. RECORDS	
18. 260X CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ACIDOSIS & DEHYDRATION ? DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE. (A) STATING THE UNDERLYING CONDITION LAST. DIABETES MELLITUS ? DUE TO OTHER SIGNIFICANT CONDITIONS CON- TRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. PSYCHOSIS					
19A. DATE OF OPERATION 2		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDER- LYING OR CONTRIBUTING CAUSE OF DEATH		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 12-1-1950 to 12-2-1950 , that I last saw the deceased alive on 8:55 A.M. , 1950 and that death occurred at 6:55 A.M. , from the causes and on the date stated above.					
23A. SIGNATURE John W. Moran		23B. ADDRESS at north ave		23C. DATE SIGNED 12-2-50	
24A. BURIAL, CREMA- TION, REMOVAL (Specify) Burial		24B. DATE 12-5-1950		24C. NAME OF CEMETERY OR CREMATORY Moreland Park	
24D. LOCATION (City, town, or county) Baltimore		24E. STATE Md.		24F. ADDRESS 2000 E. Baltimore St.	
DATE RECEIVED BY LOCAL REGISTRAR DEC 4 - 1950		REGISTRAR'S SIGNATURE Wilmington Williams, M.D.		25. FUNERAL DIRECTOR John W. Moran	



263
50-10336BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10336

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

FRANK

RICHARDSON

2. DATE
OF
DEATH

12-1-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland Baltimore

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION

MARYLAND GENERAL HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE

MARYLAND

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
BALTIMORE

D. STREET ADDRESS (If rural, give location)

2510 E. BIDDLE ST.

c. Length of stay in Baltimore

64

Yrs.
Mos.
Days

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

MARRIED

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Store Keeper

10B. KIND OF BUSINESS OR
INDUSTRY

Confectionery (R)

13. FATHER'S NAME

FRANK RICHARDSON

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown)

no

(If yes, give war or dates of service)

16. SOCIAL
SECURITY NO.

-

17. INFORMANT

ADDRESS 2510 E.

Mrs. Elizabeth Richardson Biddle St

1B.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) SHOCK

DUE TO

2 HRS.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

DUE TO

(B) MASSIVE GASTRIC HEMORRHAGE 24 HRS.

(C) UNKNOWN

II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE
WORK AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12/1, 1950, to 12/1, 1950, that I last saw the deceased alive on 12/1, 1950, and that death occurred at 5:45 P.M., from the causes and on the date stated above.

23A. SIGNATURE

Paul E. Herold

M. D.

23B. ADDRESS

Maryland General Hosp

23C. DATE SIGNED

12/1/50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

12-5-1950

24C. NAME OF CEMETERY OR CREMATORY

New Cathedral

24D. LOCATION (City, town, or county)

Baltimore

(State)

Md.

DATE RECEIVED BY
LOCAL REGISTRAR
DEC 4 - 1950

REGISTRAR'S SIGNATURE

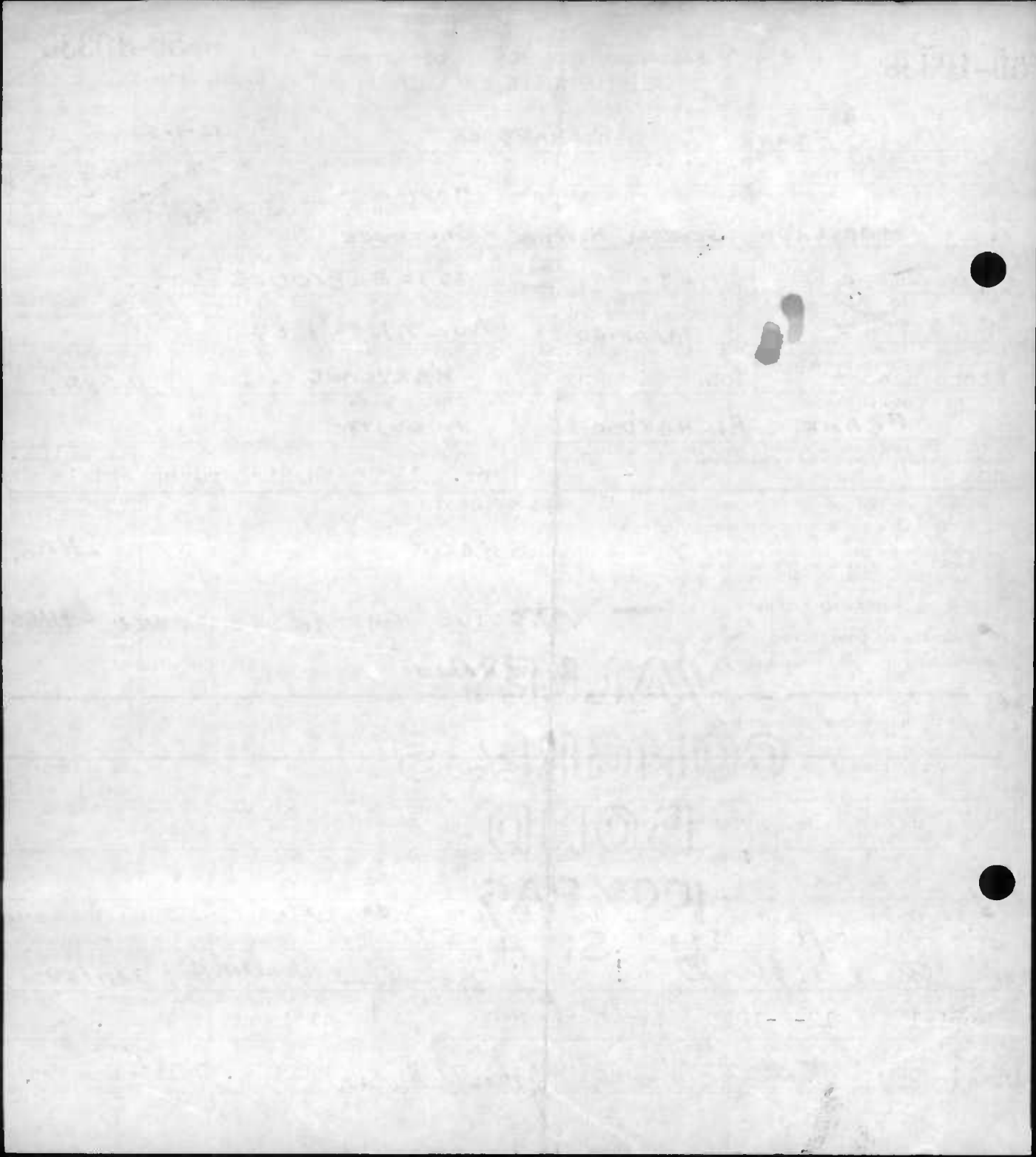
Huntington Williams, M.D.

25. FUNERAL DIRECTOR

John A. Moran

ADDRESS

3000 E. Baltimore St.



630
50-10337

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10337
Registered No.

BIRTH NO.		1. NAME OF DECEASED (Type or Print) TIMOTHY Pratt		2. DATE OF DEATH 11/30/50	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY 22-06			
B. FULL NAME OF HOSPITAL OR INSTITUTION 629 Dover St		C. CITY OR TOWN (If outside corporate limits: give RURAL and give township) Baltimore			
C. Length of stay in Baltimore 11 Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) 629 Dover St			
5. SEX male	6. COLOR OR RACE Col	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) married		8. DATE OF BIRTH Dec 125/1896	9. AGE (In years last birthday) 54
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10B. KIND OF BUSINESS OR INDUSTRY Ship yard		11. BIRTHPLACE (State or foreign country) S. Carolina	
12. CITIZEN OF WHAT COUNTRY? ✓		13. FATHER'S NAME Andy Pratt			
14. MOTHER'S MAIDEN NAME Harriett McClellan		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.		17. INFORMANT Minnie Pratt ADDRESS 629 Dover St			

MEDICAL CERTIFICATION	18. 491X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH
	(A) Acute Broncho Pneumonia		DUE TO		4 wks
	(B) Chronic Neglect		DUE TO		6 mo
	(C)				
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					

19A. DATE OF OPERATION 0		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 5/10/1950 to 11/30/1950 , that I last saw the deceased alive on 11/29/1950 , and that death occurred at 4:45 a.m. , from the causes and on the date stated above.					
23A. SIGNATURE James J. Crandall M.D.		23B. ADDRESS 142 W. Lee		23C. DATE SIGNED 11/30/50	
24A. BURIAL, CREMATION, REMOVAL (Specify) Buried		24B. DATE 12/4/50		24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.		25. FUNERAL DIRECTOR Wm. A. Jackson - 916 Penna. Ave			
OATE RECEIVED BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE Wm. A. Jackson		ADDRESS	

DEC 4 - 1950
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10-10351

CERTIFICATE OF DEATH

10-10351

Name of Deceased		Date of Birth	
Sex		Race	
Marital Status		Place of Birth	
Occupation		Cause of Death	
Time of Death		Place of Death	
Signature of Physician		Signature of Registrar	
Date of Certificate		Place of Issuance	

620
50-10338

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10338
Registered No.

1. NAME OF DECEASED (Type or Print) Jane A. Creagh		2. DATE OF DEATH 12/2/50	
3. PLACE OF DEATH: A. Baltimore City, Maryland Baltimore, Md.		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE Maryland B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION 230 E. 25th Street		C. CITY OR TOWN (If outside corporate limits, write "RURAL" and give township) Baltimore	
C. Length of stay in Baltimore 35 Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) 230 E. 25th Street	
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH June 5, 1858
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10B. KIND OF BUSINESS OR INDUSTRY -----	9. AGE (in years last birthday) 92
11. BIRTHPLACE (State or foreign country) St. Mary's Co., Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME William E. Hooper		14. MOTHER'S MAIDEN NAME Jane Wilkenson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT William E. Craig		ADDRESS 230 E. 25th Street	

18. 450.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) DUE TO (A) Myocardial Infarction	INTERVAL BETWEEN ONSET AND DEATH 4 Mo
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (B) Generalized Atherosclerosis - severe 40 yrs -	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	

19A. DATE OF OPERATION 0		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDER- LYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21B. PLACE OF INJURY (e. g., io or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from June 1950, to Dec 1950, that I last saw the deceased alive on Nov 30, 1950, and that death occurred at 1:10 P m., from the causes and on the date stated above.					
23A. SIGNATURE Thomas L. Warder Jr		23B. ADDRESS 2900 Alameda Rd		23C. DATE SIGNED 12/2/50	
24A. BURIAL, CREMA- TION, REMOVAL (Specify) Burial		24B. DATE 12/5/50		24C. NAME OF CEMETERY OR CREMATORY New Cathedral	
24D. LOCATION (City, town, or county) Baltimore, Maryland		24E. DATE RECEIVED BY LOCAL REGISTRAR DEC 4 - 1950		24F. REGISTRAR'S SIGNATURE Huntington Williams, M.D.	
25. FUNERAL DIRECTOR		ADDRESS 46 W. Meade and Lou 805 N. Calvert St.			

BEVERLY-AR

100-100

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620
50-10339
BIRTH NO.BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50-10339

1. NAME OF DECEASED (Type or Print) ANNIE MYERS			2. DATE OF DEATH November 28, 1950		
3. PLACE OF DEATH: A. Baltimore City, Maryland Balto. City			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY		
B. FULL NAME OF HOSPITAL OR INSTITUTION Maryland General Hospital			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore		
C. Length of stay in Baltimore Life			D. STREET ADDRESS (If rural, give location) 802 Bradley Street BRADLEY		
5. SEX Female	6. COLOR OR RACE Colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Sept. 19, 1860	9. AGE (In years last birthday) 90	10. Under 1 Year Months: Days: 11. Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10B. KIND OF BUSINESS OR INDUSTRY At Home		
11. BIRTHPLACE (State or foreign country) Baltimore City			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Unknown			14. MOTHER'S MAIDEN NAME Fannie Myers		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No			16. SOCIAL SECURITY NO.		
17. INFORMANT John Myers			ADDRESS 802 Bradley St		

18. 4221 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	CAUSE OF DEATH (A) Arteriosclerotic cardiovascular disease DUE TO (B) DUE TO (C)	INTERVAL BETWEEN ONSET AND DEATH
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19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Inspection & Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE William Wilson	23B. CHIEF MEDICAL EXAMINER..... M.D. ASSISTANT MEDICAL EXAMINER..... MEDICAL INVESTIGATOR.....	23C. DATE SIGNED Nov. 28, 1950
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial	24B. DATE 12/4/50	24C. NAME OF CEMETERY OR CREMATORY Mt Calvary Cem.
24D. LOCATION (City, town, or county) Brooklyn Md.		25. FUNERAL DIRECTOR Eloy S. Wilson, 1000 Brantley Ave

DATE RECEIVED BY LOCAL REGISTRAR DEC 4 - 1950	REGISTRAR'S SIGNATURE [Signature]	ADDRESS 93D
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3-10530

RECEIVED BY AIR MAIL

CERTIFICATE OF DEATH

3-10530

Page 1

DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

1

2

3

4

5

6

7

8

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514
0-10340BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10340

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

LENA CAMPBELL

2. DATE
OF
DEATH

DEC 1, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

A2

B. FULL NAME OF
HOSPITAL OR
INSTITUTION

JONES HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence
A. STATE B. COUNTY before admission)

MARYLAND

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

BALTIMORE

D. STREET ADDRESS (If rural, give location)

2271 MADISON AVE.

C. Length of stay in Baltimore

66 yrs.

5. SEX

FEMALE

6. COLOR OR RACE

COLORED

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

MARRIED

10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR
INDUSTRY

Home

13. FATHER'S NAME

Richard W. Wheeler

8. DATE OF BIRTH

8-4-84

9. AGE (in years
last birthday)

66

If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.

11. BIRTHPLACE (State or foreign country)

Balto Md.

12. CITIZEN OF
WHAT COUNTRY?

14. MOTHER'S MAIDEN NAME

?

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

JONES HOPKINS HOSPITAL

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A)

DUE TO

Carcinoma of Bladder

INTERVAL BETWEEN
ONSET AND DEATH

6 mos

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

Diabetes Mellitus

2 year

19A. DATE OF OPERATION

11/15/50

19B. MAJOR FINDINGS OF OPERATION

Carcinomatous

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDER-
LYING OR CONTRIBUTING
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE
WORK AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11-4 - 1950, to 12-1 - 1950, that I last saw the
deceased alive on 12-1, 1950, and that death occurred at 6:00 a.m., from the causes and on the date stated above.

23A. SIGNATURE

J. Howell Webb

M. D.

23B. ADDRESS

JONES HOPKINS HOSPITAL

23C. DATE SIGNED

12/1/50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

Burial Dec 4/1950

Arbutus Mem. Pk.

Balto. Md.

DEC 4 - 1950

Washington Williams, M.D.

Halland Funeral Home

1631 D and Hill Ave

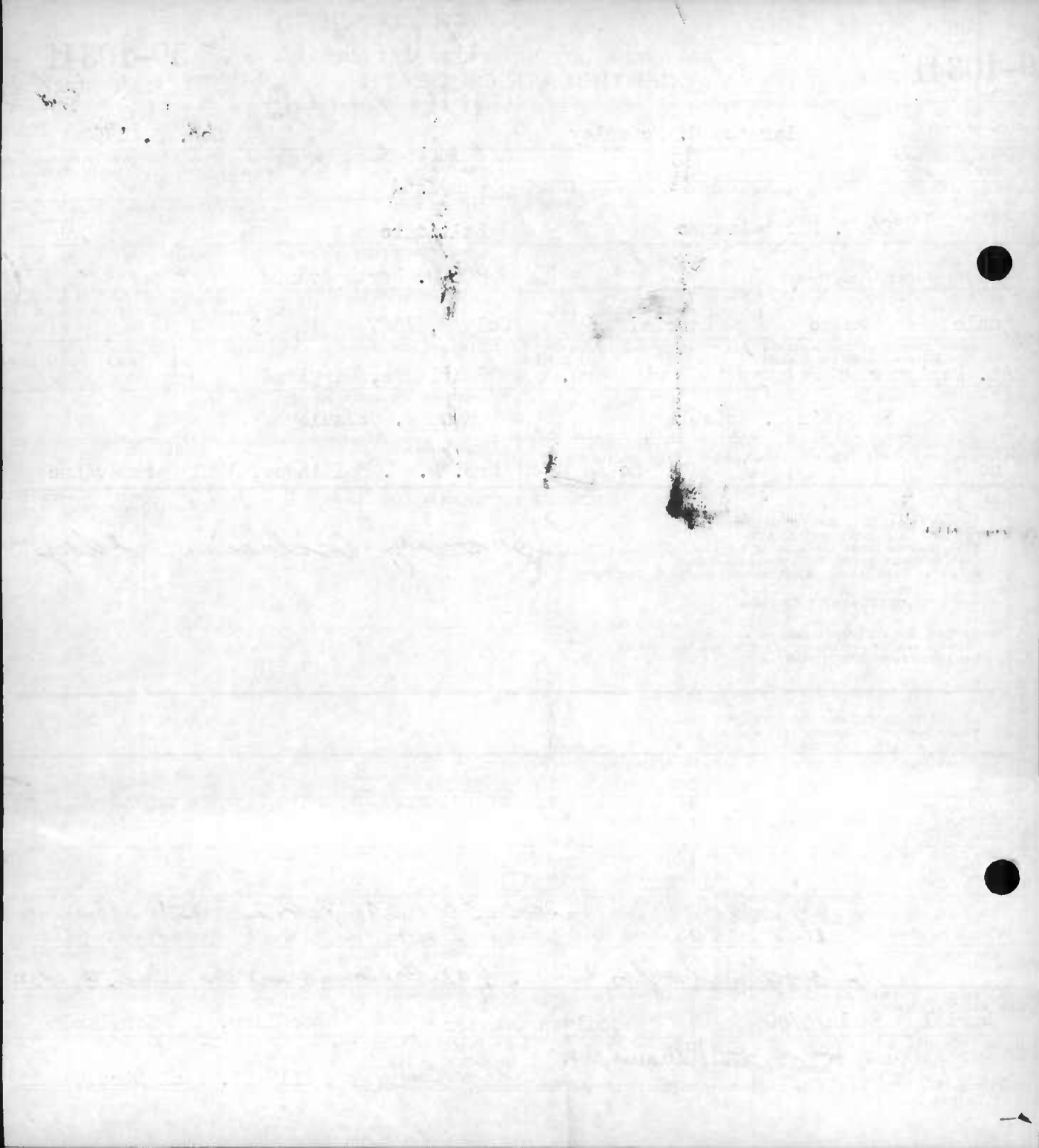
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BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		50-10341		Registered No.	
1. NAME OF DECEASED (Type or Print)		Clarence G. McCauley		2. DATE OF DEATH		Dec. 2, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		A. STATE		B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION		Maryland		C. CITY OR TOWN		(If outside corporate limits, write RURAL and give township)	
806 W. North Avenue		Baltimore		D. STREET ADDRESS (If rural, give location)		806 W. North Avenue 13-02	
C. Length of stay in Baltimore		Yrs. Mos. Days		8. DATE OF BIRTH		9. AGE (In years last birthday)	
5. SEX		6. COLOR OR RACE		7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)		11. BIRTHPLACE (State or foreign country)	
male		white		Married		Baltimore, Maryland	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY?			
Ret. Designer of Pajamas		Liberty Manu. Co.					
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.	
Benjamin F. McCauley		Emma L. McCauley		no		no	
17. INFORMANT		ADDRESS		18. 4201 I		CAUSE OF DEATH	
Mrs. H. E. Bollinger, 1701 Park Avenue				DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
				(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		2 days	
				DUE TO			
				(B) DUE TO			
				(C) DUE TO			
				OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Dec. 30, 1950, to Feb. 2, 1951, that I last saw the deceased alive on Feb. 1, 1951, and that death occurred at 2:40 A.M., from the causes and on the date stated above.		23A. SIGNATURE		23B. ADDRESS		23C. DATE SIGNED	
Lloyd E. Sagley		3902 Greenmount Ave.		Dec. 2, 1950			
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)	
burial		12/5/50		Woodlawn Cemetery		Woodlawn, Maryland	
DATE RECEIVED BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR		ADDRESS	
DEC 4-1950		Huntington Williams, M.D.		Wm. Cook & Co.		1217 St. Paul Street	

03346

94a



50-10342

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10342

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

James Shirley Wilson

2. DATE
OF
DEATH

Dec. 2, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION

St. Joseph's Hospital (DCH)

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

B. COUNTY

Md

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Balt'o

D. STREET ADDRESS (If rural, give location)

2640 Nantuxden Ave 12-07

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

Married

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Railroad Conductor

10B. KIND OF BUSINESS OR INDUSTRY

Panna R.R

8. DATE OF BIRTH

11/9/1875

9. AGE (In years last birthday)

75

11 Under 1 Year Months Days

11 Under 24 Hours Hours Min.

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

James Wilson

14. MOTHER'S MAIDEN NAME

Elizabeth Raver

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Flora E. Lober 310 Painter Ave

18. 420.1

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

Coronary Disease

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT ☐ NOT WHILE ☐ WORK ☐ AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

Wm. H. Kammner, D.

M.D.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒

23C. DATE SIGNED

Dec. 2, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

12/5/50

24C. NAME OF CEMETERY OR CREMATORY

London Park

24D. LOCATION (City, town, or county) (State)

Balt'o, Md.

DATE RECEIVED BY LOCAL REGISTRAR

DEC 4 - 1950

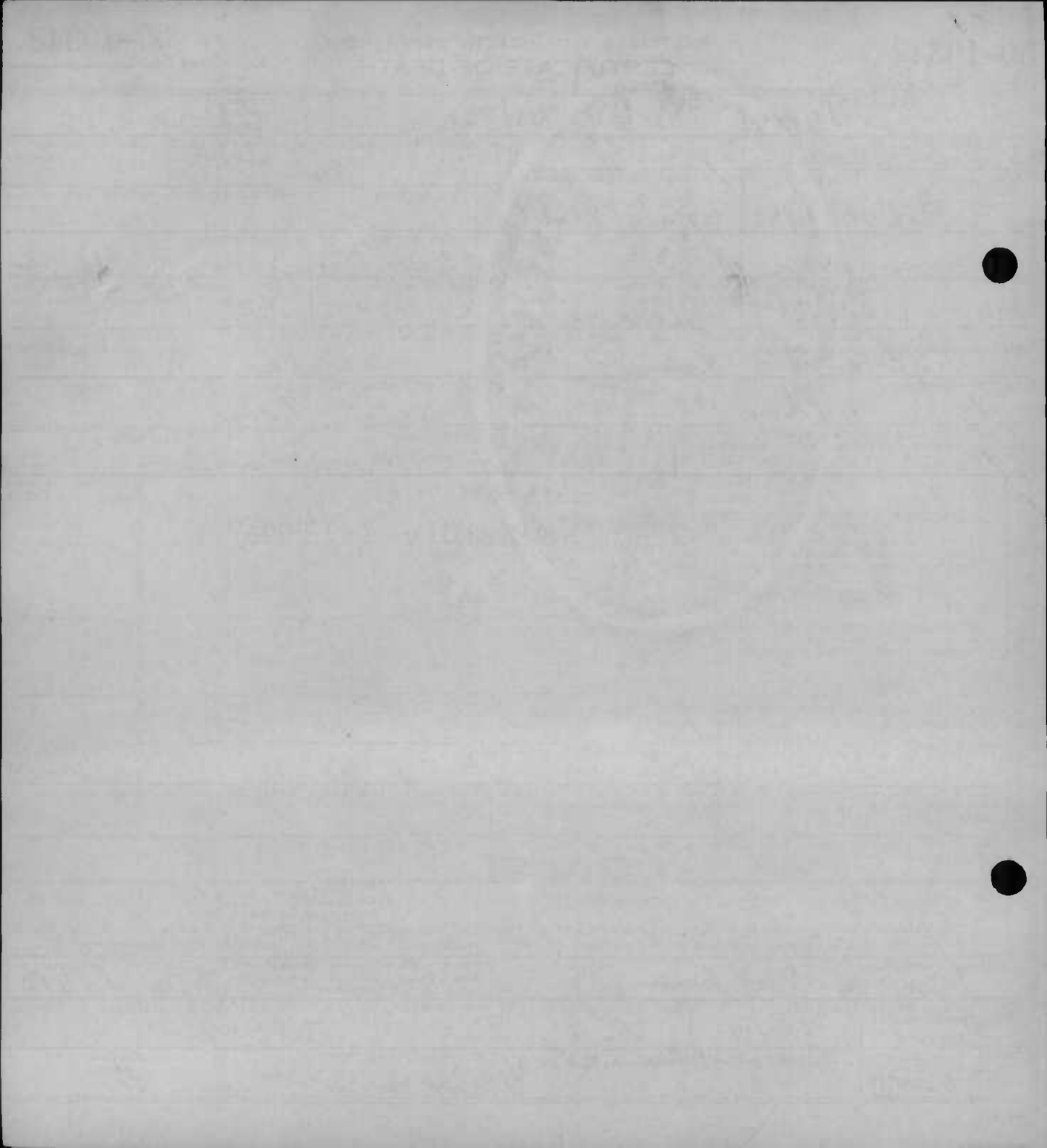
REGISTRAR'S SIGNATURE

Wm. H. Kammner, M.D.

25. FUNERAL DIRECTOR

ADDRESS

Wm. Cook Inc. 1217 St. Paul St.



626

50-10343

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10343

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

LOUIS GREGORIOS

2. DATE
OF
DEATH12.3.1950
12.20 PM

3. PLACE OF DEATH:

A. Baltimore City, Maryland Baltimore

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR INSTITUTION Mercy Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

C. CITY OR TOWN

Balto

D. STREET ADDRESS (If rural, give location)

937 Homestead St 9-05

5. SEX

Male

6. COLOR OR RACE

white

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

married

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Retired Butcher

10B. KIND OF BUSINESS OR INDUSTRY

Fox Packing Co

13. FATHER'S NAME

(Unknown)

Gregorios

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Margaret E. Gregorios 937 Homestead St.

18. 150X

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A)

Cancer of the esophagus

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

9.21.10.10.1950

19B. MAJOR FINDINGS OF OPERATION

Cancer of esophagus

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT WORK ☐NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 12.20 PM., from the causes and on the date stated above.

23A. SIGNATURE

Julius Kolaczkowski

M. D.

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

12/6/50

24C. NAME OF CEMETERY OR CREMATORY

Loudon Park

24D. LOCATION (City, town, or county)

Balto. Md.

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Washington Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

DEC 4 - 1950

Wm Cook Inc. 1217 St. Paul St.

VS 150

Julius Kolaczkowski

46a

MEDICAL CERTIFICATION

STATE OF TEXAS
COUNTY OF DALLAS

DEED OF TRUST

THIS DEED OF TRUST WAS MADE AND SIGNED BY THE PARTIES HEREIN

ON THE 15TH DAY OF JANUARY, 1961

AT DALLAS, TEXAS

IN WITNESS WHEREOF, THE PARTIES HAVE HEREUNTO SIGNED THEIR NAMES

AND SEAL, AND THE SAME HAVE BEEN PUBLICLY READ AND

THE SAME HAVE BEEN CORRECTED AND RECORDED IN THE PUBLIC

RECORDS OF THE COUNTY OF DALLAS, TEXAS

ON THE 15TH DAY OF JANUARY, 1961

AT DALLAS, TEXAS

IN WITNESS WHEREOF, THE PARTIES HAVE HEREUNTO SIGNED THEIR NAMES

AND SEAL, AND THE SAME HAVE BEEN PUBLICLY READ AND

THE SAME HAVE BEEN CORRECTED AND RECORDED IN THE PUBLIC

RECORDS OF THE COUNTY OF DALLAS, TEXAS

ON THE 15TH DAY OF JANUARY, 1961

AT DALLAS, TEXAS

IN WITNESS WHEREOF, THE PARTIES HAVE HEREUNTO SIGNED THEIR NAMES

AND SEAL, AND THE SAME HAVE BEEN PUBLICLY READ AND

THE SAME HAVE BEEN CORRECTED AND RECORDED IN THE PUBLIC

RECORDS OF THE COUNTY OF DALLAS, TEXAS

ON THE 15TH DAY OF JANUARY, 1961

AT DALLAS, TEXAS

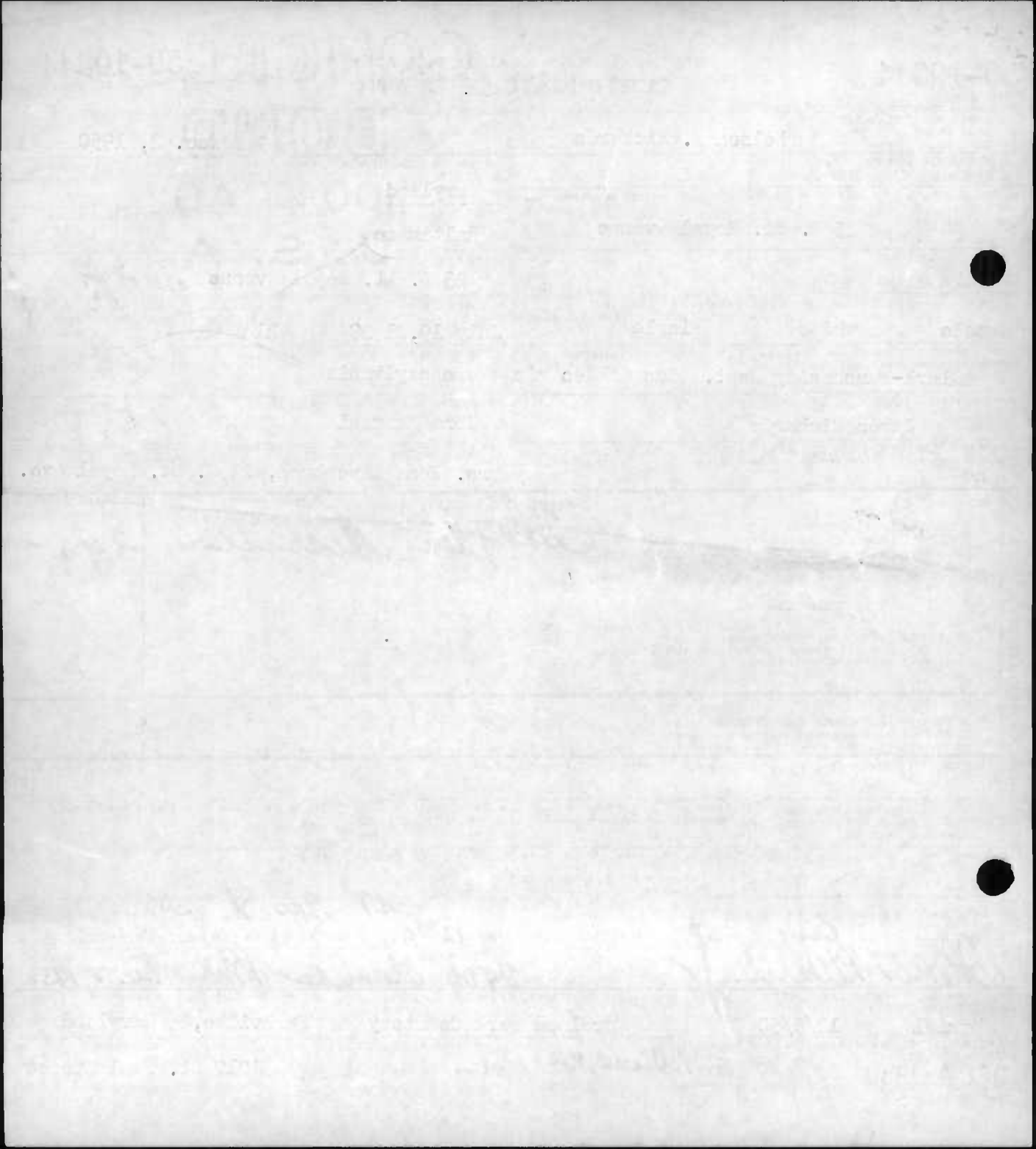
IN WITNESS WHEREOF, THE PARTIES HAVE HEREUNTO SIGNED THEIR NAMES

D. Thomas
3290 Alameda Blvd
50-10344 S

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10344
Registered No.

1. NAME OF DECEASED (Type or Print) Nelson E. Richards		2. DATE OF DEATH Dec. 2, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION 23 W. Mt. Royal Avenue		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore	
C. Length of stay in Baltimore		D. STREET ADDRESS (If rural, give location) 23 W. Mt. Royal Avenue 11-02	
5. SEX male	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) single	8. DATE OF BIRTH July 19, 1929
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk-Purchasing Dept. Gas & Electric		10B. KIND OF BUSINESS OR INDUSTRY	
13. FATHER'S NAME James Richards		14. MOTHER'S MAIDEN NAME Iona Emanuel	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Iona Lavenburg, 23 W. Mt. Royal Ave.		ADDRESS	
18. 201X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH Ischymic Disease (A) DUE TO (B) DUE TO (C) DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		INTERVAL BETWEEN ONSET AND DEATH 2 yrs -	
19A. DATE OF OPERATION 0		19B. MAJOR FINDINGS OF OPERATION	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME (Month) (Day) (Year) (Hour) INJURY	
21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 1947 to Dec 1 , 19 50 , that I last saw the deceased alive on Dec 1 , 19 50 , and that death occurred at 12:30 A. m. , from the causes and on the date stated above.			
23A. SIGNATURE Thomas Richards		23B. ADDRESS 3290 Alameda Blvd	
23C. DATE SIGNED Dec 8, 1950		23D. SIGNATURE Wm. Cook, Inc.	
24A. BURIAL, CREMATION, REMOVAL (Specify) burial		24B. DATE 12/5/50	
24C. NAME OF CEMETERY OR CREMATORY Moreland Park Cemetery		24D. LOCATION (City, town, or county) (State) Parkville, Maryland	
DATE RECEIVED BY LOCAL REGISTRAR DEC 4 - 1950		25. FUNERAL DIRECTOR Wm. Cook, Inc.	
REGISTRAR'S SIGNATURE William Williams, M.D.		ADDRESS 1217 St. Paul Street	



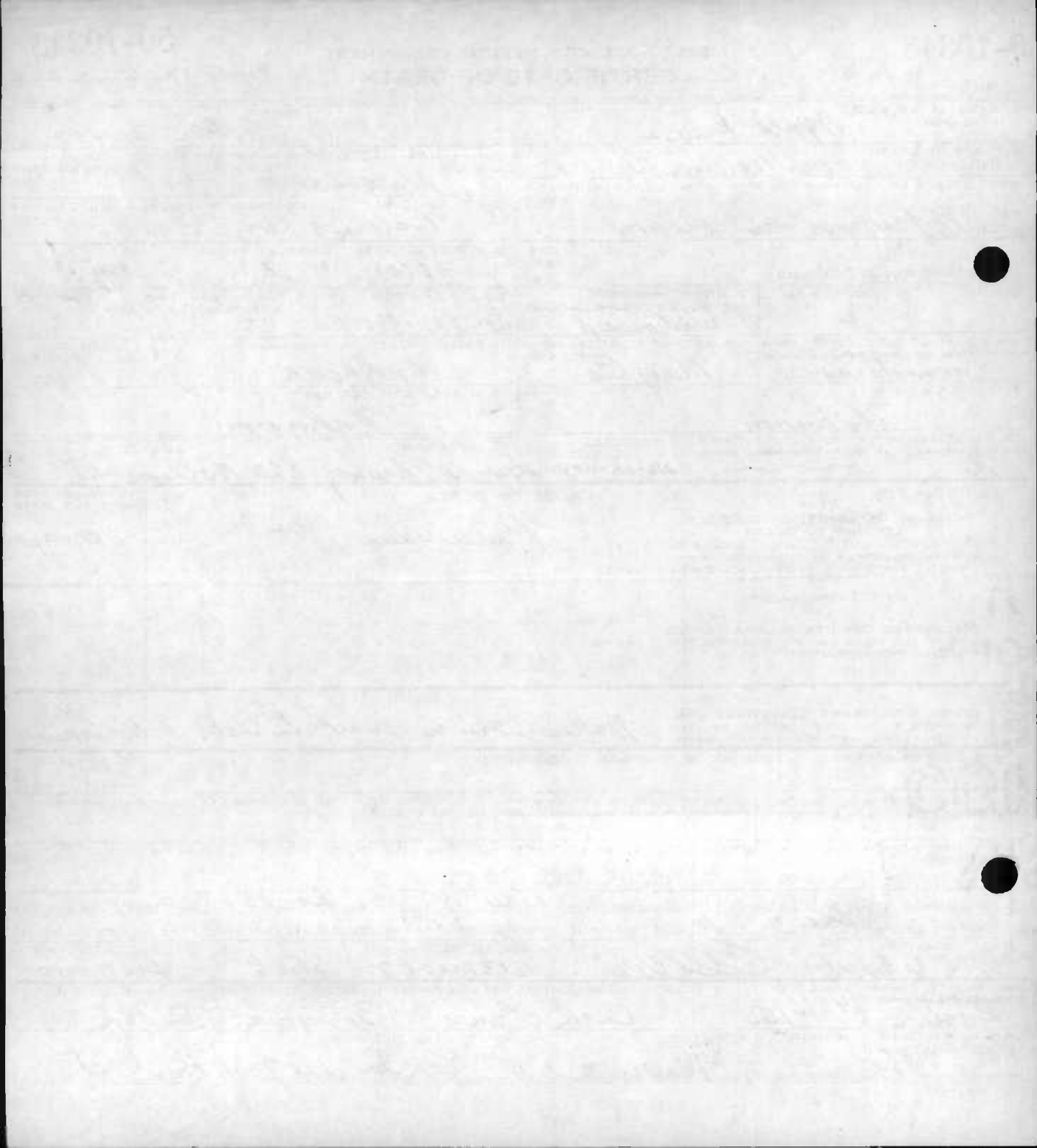
20
0-10345BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10345

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <i>Agnes Krausz</i>		2. DATE OF DEATH <i>Dec 3, 1950</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <i>Baltimore City, MD</i>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>South Baltimore Gen. Hospital</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore City</i>	
C. Length of stay in Baltimore Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) <i>3610 3rd St. 25-04</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Widowed</i>	8. DATE OF BIRTH <i>Apr. 23, 1880</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Seamstress</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>May Co DEPT. STORE</i>	9. AGE (In years last birthday) <i>70</i> If Under 1 Year Months: Days If Under 24 Hours Hours: Min.
13. FATHER'S NAME <i>Unknown</i>		11. BIRTHPLACE (State or foreign country) <i>Unknown</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>No</i>		12. CITIZEN OF WHAT COUNTRY? <i>Unknown</i>	
16. SOCIAL SECURITY NO. <i>26-05-1194</i>		17. INFORMANT ADDRESS <i>Howard J. Krausz 820 Hollins St.</i>	
18. <i>493X I</i> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <i>Pneumonia, Rt</i> DUE TO INTERVAL BETWEEN ONSET AND DEATH <i>30 days</i> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO (C) <i>Arterio-sclerotic Heart Disease</i> NOT DETERMINED			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION <i>0</i>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>Nov. 8, 1950</i> , to <i>Dec 3, 1950</i> , that I last saw the deceased alive on <i>Dec 3, 1950</i> , and that death occurred at <i>2:45 A.M.</i> , from the causes and on the date stated above.			
23A. SIGNATURE <i>D. C. D. Quirk</i>		23B. ADDRESS <i>1213 KICOR ST. SB64</i>	
23C. DATE SIGNED <i>Dec 3, 1950</i>			
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Buried</i>		24B. DATE <i>12/6/50</i>	
24C. NAME OF CEMETERY OR CREMATORY <i>Oak Lawn</i>		24D. LOCATION (City, town, or county) (State) <i>Eastern Ave. Extended</i>	
DATE RECEIVED BY LOCAL REGISTRAR <i>DEC 4 - 1950</i>		REGISTRAR'S SIGNATURE <i>William Williams</i>	
25. FUNERAL DIRECTOR <i>Wm. Cook Inc.</i>		ADDRESS <i>1217 St. Paul St.</i>	



300

50-10346

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10346

Registered No.

1. NAME OF DECEASED (Type or Print)		LOUIS FRANKLIN REED		2. DATE OF DEATH Dec. 2, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md.			
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2745 W. Lafayette Ave.		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore			
D. STREET ADDRESS (If rural, give location) 2745 W. Lafayette Ave.		16-06			
5. SEX male		6. COLOR OR RACE white		7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) married	
8. DATE OF BIRTH Jan. 6, 1883		9. AGE (In years last birthday) 67		10. UNDER 1 Year Months: Days 11. UNDER 24 Hours Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Boat Caulker		10B. KIND OF BUSINESS OR INDUSTRY Caulking		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME Franklin Reed			
14. MOTHER'S MAIDEN NAME Harrietta ?		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) -			
16. SOCIAL SECURITY NO. 216-09-8563		17. INFORMANT M-s. Louis F. Reed - 2745 W. Lafayette Av.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 154X I CAUSE OF DEATH Carcinoma of Rectum DUE TO with generalized metastasis DUE TO DUE TO INTERVAL BETWEEN ONSET AND DEATH one year 2 mth		19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Operation June 2, 1950 - Calostomy -			
19A. DATE OF OPERATION June 2/1950		19B. MAJOR FINDINGS OF OPERATION Carcinoma of Rectum with metastases		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from May 29, 1950, to Dec 2, 1950, that I last saw the deceased alive on Dec 2, 1950, and that death occurred at 5 p.m., from the causes and on the date stated above.					
23A. SIGNATURE J. L. Gierler		23B. ADDRESS 2318 Euter Place		23C. DATE SIGNED Dec 4/50	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/5/50		24C. NAME OF CEMETERY OR CREMATORY Loudon Park	
24D. LOCATION (City, town, or county) (State) Balto., Md.		25. FUNERAL DIRECTOR Wm. J. Tichenor & Sons Address: 467 Md.			
DATE RECEIVED BY LOCAL REGISTRAR DEC 4 - 1950		REGISTRAR'S SIGNATURE Wm. J. Tichenor & Sons			

10-11-18

ALL INFORMATION CONTAINED
HEREIN IS UNCLASSIFIED

10-11-18

DATE OF REVIEW: 10-11-18

REVIEWED BY: [illegible]

DATE OF REVIEW: 10-11-18

REVIEWED BY: [illegible]

DATE OF REVIEW: 10-11-18

REVIEWED BY: [illegible]

DATE OF REVIEW: 10-11-18

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361
50-10347BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10347

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) FREDERICK H. RITTER HOFF			2. DATE OF DEATH 12/2/50		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE MARYLAND B. COUNTY		
B. FULL NAME OF HOSPITAL OR INSTITUTION MERCY HOSP			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE		
D. Length of stay in Baltimore Yrs. Mos. Days			E. STREET ADDRESS (If rural, give location) 2806 HARFORD RD. 9-06		
5. SEX M	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH 26 FEB 1892	9. AGE (In years, last birthday) 68	If Under 1 Year Months: Days If Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BUSINESS - SELF			10B. KIND OF BUSINESS OR INDUSTRY BARBER		11. BIRTHPLACE (State or foreign country) GERMANY
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME HENRY RITTER HOFF		
14. MOTHER'S MAIDEN NAME SOPHIE			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) UNKNOWN		
16. SOCIAL SECURITY NO. ?			17. INFORMANT ADDRESS MRS. MARGARET RITTER HOFF 2806 HARFORD RD #8		

18. **331X**

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO

Cerebral vascular accident

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

Generalized arteriosclerosis

II

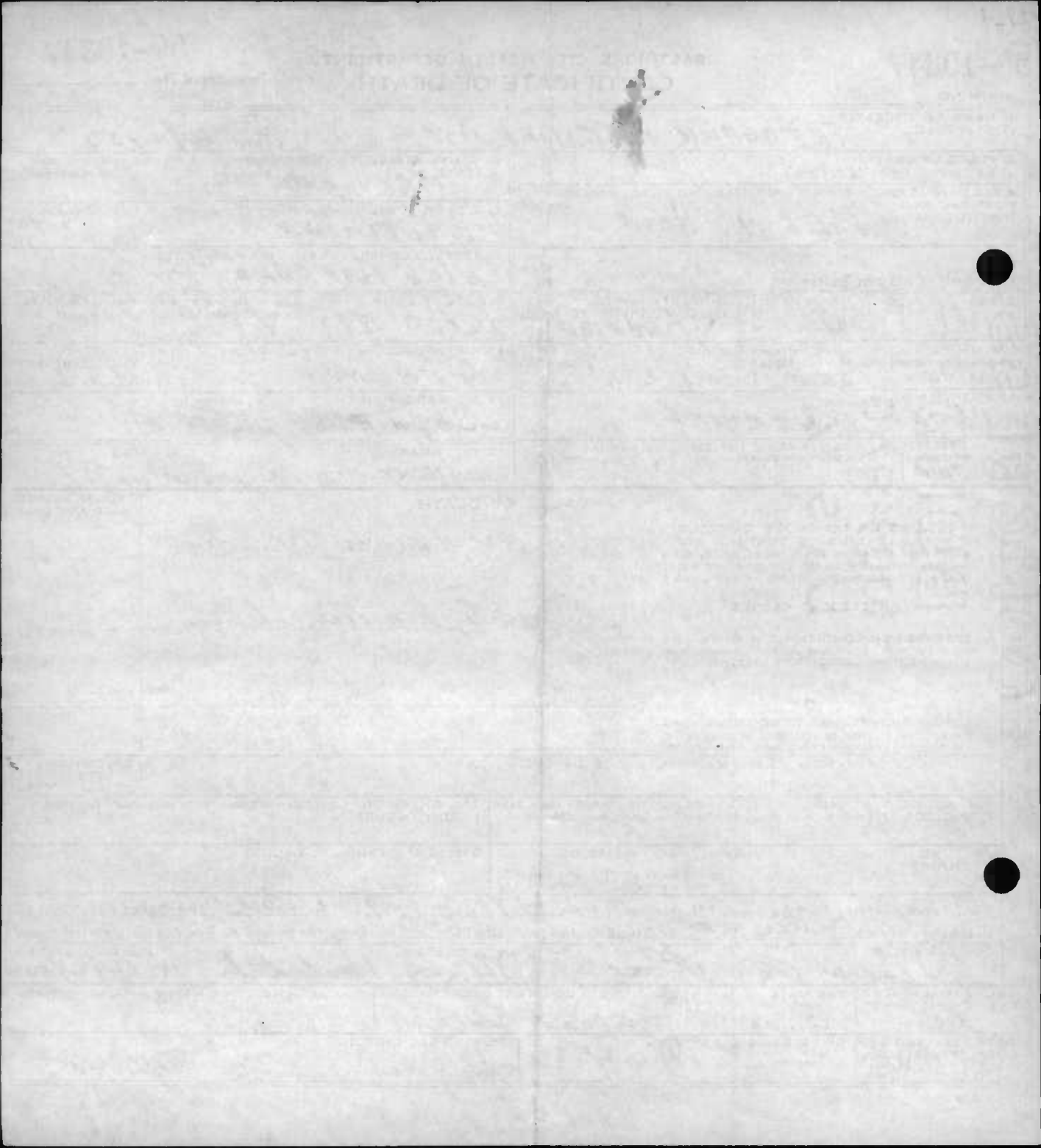
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION 2		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 14 Nov. 1950 , to 2 Dec. 1950 , that I last saw the deceased alive on 2 Dec. 1950 , and that death occurred at 6:45 m., from the causes and on the date stated above.					
23A. SIGNATURE Oliver R. Road		23B. ADDRESS Mercy Hospital		23C. DATE SIGNED 12/2/50	
24A. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 12/5/50		24C. NAME OF CEMETERY OR CREMATORY BALTIMORE CEMETERY	
24D. LOCATION (City, town, or county) (State) BALTO. MD		24E. DATE RECEIVED BY LOCAL REGISTRAR DEC 4 - 1950		24F. REGISTRAR'S SIGNATURE William J. Williams, M.D.	
24G. FUNERAL DIRECTOR Wm. J. Tichner & Sons Inc.		24H. ADDRESS Balto. Md.		24I. VS 150	

7408F

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260
50-10348BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50-10348

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

CARL MOPHERSON FISHER

2. DATE
OF
DEATH

DECEMBER 2, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION

South Baltimore General Hospital

Yrs.
Mos.
Days

Length of stay in Baltimore

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Married

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Foreman

10B. KIND OF BUSINESS OR INDUSTRY

DuPont, Inc.

13. FATHER'S NAME

James Lee Fisher

CHEMICALS (4)

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown)

yes

(If yes, give war or dates of service)

World War I

16. SOCIAL SECURITY NO.

8. DATE OF BIRTH

July 11, 1895

9. AGE (in years last birthday)

55

If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF
WHAT COUNTRY?

14. MOTHER'S MAIDEN NAME

Emmaline Hollandsworth

17. INFORMANT

ADDRESS

Md.

Mrs. Mildred A. Fisher - Princess Anne

CAUSE OF DEATH

18. 4201

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A)

DUE TO

Coronary Occlusion

one day

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from December 1, 1950, to December 2, 1950 that I last saw the deceased alive on Dec. 2, 1950 and that death occurred at 1:05 a.m., from the causes and on the date stated above.

23A. SIGNATURE

Martin C. Macapangan M. D.

23B. ADDRESS

South Balto. Gen. Hosp.

23C. DATE SIGNED

Dec. 2, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

12/5/50

24C. NAME OF CEMETERY OR CREMATORY

Allen

24D. LOCATION (City, town, or county)

Allen, Md.

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Eustorgio Williams, M.D.

25. FUNERAL DIRECTOR

24m. J. Pickens & Sons - Balto

ADDRESS

Md.

VS 150

523 4R

94a

UNITED STATES GOVERNMENT

OFFICE OF THE SECRETARY OF THE ARMY

WASHINGTON, D. C.

1945

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453-
50-10349BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50-10349
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)*Beatrice E. Coleman*2. DATE
OF
DEATH*Mar 2 1950*

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION*Garrison Nursing Home*
*2803 Garrison Blvd.*4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE*Md.*

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore

D. STREET ADDRESS (If rural, give location)

1812 N. Monroe St.

c. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

female

6. COLOR OR RACE

*white*7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)
married

8. DATE OF BIRTH

*Jan. 22, 1904*9. AGE (In years
last birthday)*46*If Under 1 Year
Months: Days
If Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)*housewife*10B. KIND OF BUSINESS OR
INDUSTRY*at home*

11. BIRTHPLACE (State or foreign country)

*Maryland*12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

George Ewell

14. MOTHER'S MAIDEN NAME

*Florence Schettel*15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)*no*16. SOCIAL
SECURITY NO.
no

17. INFORMANT

ADDRESS

*Mr. Charles J. Coleman 1812 N. Monroe St.*18. *170X*

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A)

Carcinoma of breast, right
*with generalized metastases.**7 years*

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

Feb. 1943

19B. MAJOR FINDINGS OF OPERATION

Carcinoma of breast, right

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *Feb 1*, 1943, to *Mar 2*, 1950, that I last saw the
deceased alive on *Mar 2*, 1950, and that death occurred at *12 P. m.*, from the causes and on the date stated above.

23A. SIGNATURE

William E. Moore

M. D.

23B. ADDRESS

100 E 33 St. Baltimore Md

23C. DATE SIGNED

*Mar 2 1950*24A. BURIAL, CREMA-
TION, REMOVAL (Specify)*Burial*

24B. DATE

12/6/50

24C. NAME OF CEMETERY OR CREMATORY

Baltimore National Cem.

24D. LOCATION (City, town, or county)

Balto., Md.

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

William E. Moore

25. FUNERAL DIRECTOR

ADDRESS

Thos. J. Pichon - Baltimore

1994, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 26

100

634
50-10350BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50-10350

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

ANNA C. BORTELL

2. DATE
OF
DEATH

Dec. 2, 1950.

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION

UNION MEMORIAL HOSPITAL

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE

MD.

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
BALTIMORE

D. STREET ADDRESS (If rural, give location)

2 WYNDHURST AVE. 27-12

c. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

F

6. COLOR OR RACE

W

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

S

8. DATE OF BIRTH

Aug. 25, 1892

9. AGE (In years last birthday)

58

If Under 1 Year

If Under 24 Hours

Months: Days

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

NURSE

10B. KIND OF BUSINESS OR INDUSTRY

nursing

13. FATHER'S NAME

JOHN BORTELL

PRIVATE

11. BIRTHPLACE (State or foreign country)

BALTIMORE Md.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

14. MOTHER'S MAIDEN NAME

THERESA CUNNINGHAM

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

none

16. SOCIAL
SECURITY NO.

none

17. INFORMANT

ADDRESS

Mrs. Wm. H. Morris - 2102 Maryland Ave.

18. 420.01

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A)

Coronary thrombosis

DUE TO

INTERVAL BETWEEN
ONSET AND DEATH

12 hours

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

Arteriosclerotic heart disease

DUE TO

(C)

Hypertensive Cardiovascular Disease

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from DEC. 1, 1950, to DEC. 2, 1950, that I last saw the deceased alive on DEC. 2, 1950, and that death occurred at 6:55 AM., from the causes and on the date stated above.

23A. SIGNATURE

Dr. F. Cox 3rd

23B. ADDRESS

M. D.

Union Memorial Hospital

23C. DATE SIGNED

12-2-50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

12/6/50

24C. NAME OF CEMETERY OR CREMATORY

Lorraine Cem.

24D. LOCATION (City, town, or county)

Woodlawn, Md.

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

DEC 4 - 1950

REGISTRAR'S SIGNATURE

L. H. Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

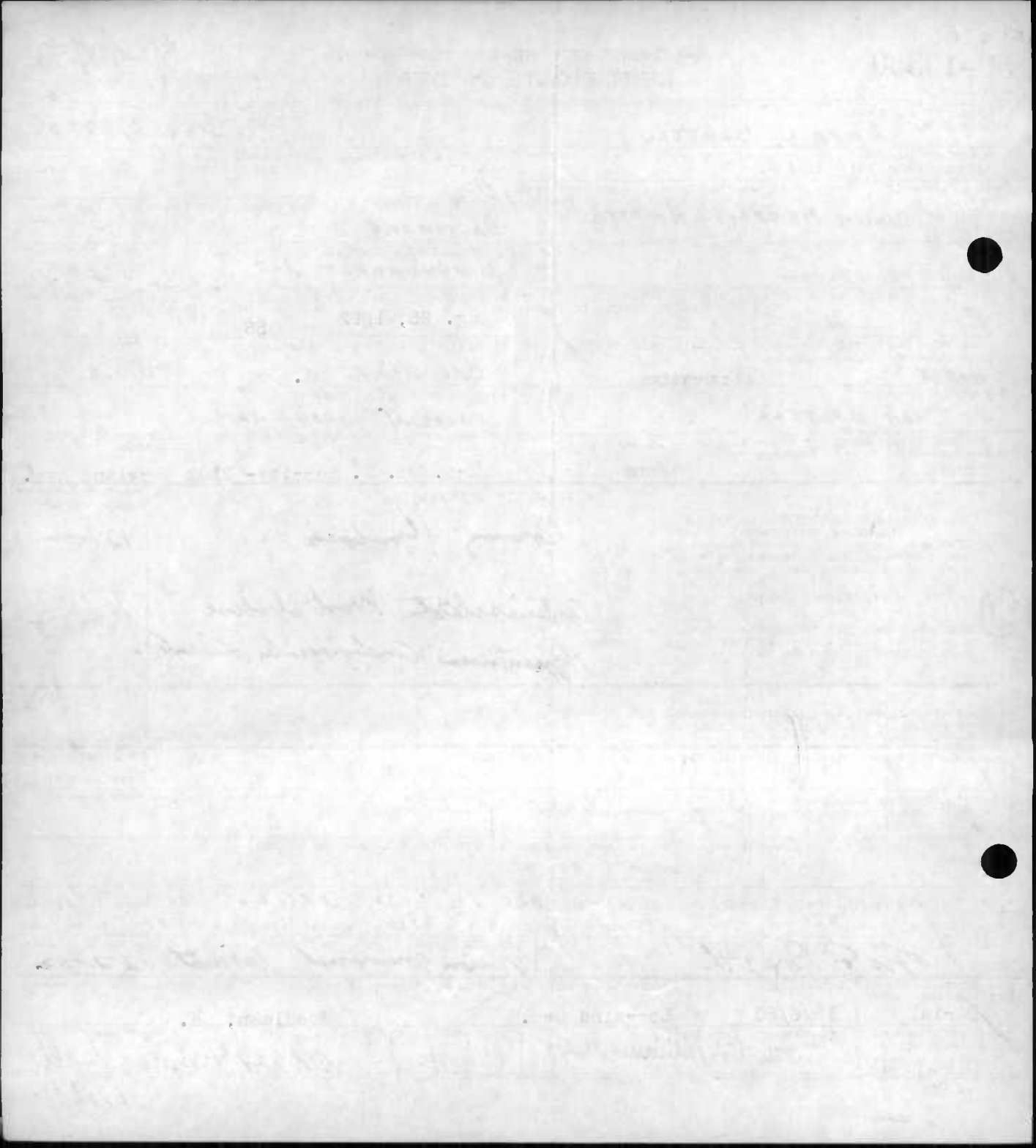
Wm. J. Pickens & Sons - Balto

VS 150

05880

93D Md.

MEDICAL CERTIFICATION



**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

50-10351

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Annice Lucas

2. DATE
OF DEATH

Dec. 3-1950

3. PLACE OF DEATH:

a. Baltimore City, Maryland *520 N. Vincent*

b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE *520 N. Vincent* B. COUNTY

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Balto

c. Length of stay in Baltimore

45 yrs

5. SEX

Female Colored

6. COLOR OR RACE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

May. 1875

9. AGE (In years last birthday)

75 yrs

10 Under 1 Year Months: Days

11 Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Calvert Co. Md

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Brown Benjamin

14. MOTHER'S MAIDEN NAME

Aluthia Cully

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

736 N. Carrollton Ave
Lum. Gross

ADDRESS

18. *171X*

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

General Carcinoma

INTERVAL BETWEEN ONSET AND DEATH

18 mos

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

Carcinoma of cervix

2 years

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

arteriosclerosis

44 years

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from *12-1-1950* to *12-3-1950* that I last saw the deceased alive on *12-3-1950* and that death occurred at *3:15 p.m.* from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

See Document File 50-10351
12/13/50 ES

425
10-10352
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50-10352

1. NAME OF DECEASED (Type or Print) IDA MAE WILSON			2. DATE OF DEATH December 2, 1950		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Anne Arundel		
B. FULL NAME OF HOSPITAL OR INSTITUTION University Hospital			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pasadena		
C. Length of stay in Baltimore Life Yrs. Mos. Days			D. STREET ADDRESS (If rural, give location) Fort Smallwood Road 5200		
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) widow	8. DATE OF BIRTH Oct. 22, 1871	9. AGE (In years last birthday) 74	10. Under 1 Year Months: Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			11. BIRTHPLACE (State or foreign country) Balto. Md		12. CITIZEN OF WHAT COUNTRY? ?
13. FATHER'S NAME Snyder			14. MOTHER'S MAIDEN NAME ?		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no		16. SOCIAL SECURITY NO. none	17. INFORMANT Margaret A. Disney - Fort Smallwood Rd		
18. 4221 I CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIB-UTING <input type="checkbox"/> CAUSE OF DEATH.		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that I took charge of the remains described above, held an Inspection & Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .					
23A. SIGNATURE W. H. Smith		23B. CHIEF MEDICAL EXAMINER..... M.D. ASSISTANT MEDICAL EXAMINER..... MEDICAL INVESTIGATOR.....		23C. DATE SIGNED Dec. 2, 1950	
24A. BURIAL, CREMA-TION, REMOVAL (Specify) Burial	24B. DATE Dec. 4, 1950	24C. NAME OF CEMETERY OR CREMATORY Holy Cross	24D. LOCATION (City, town, or county) (State) Pitchoi Highway - Balto Md		
DATE RECEIVED BY LOCAL REGISTRAR DEC 4 - 1950		REGISTRAR'S SIGNATURE Huntington Williams, M.D.		25. FUNERAL DIRECTOR KRAUSE FUNERAL HOME - 1216 S. CHARLES	

MEDICAL CERTIFICATION

BALTO 3093D ✓ ST

8-10-58

STATE OF NEW YORK
CERTIFICATE OF DEATH

8-10-58

Name of Deceased		Date of Birth		Sex		Race		Marital Status		Occupation	
John Doe		1-1-1900		Male		White		Married		Teacher	
Place of Birth		Date of Death		Time of Death		Cause of Death		Manner of Death		Place of Death	
New York City		8-10-58		10:00 AM		Heart Disease		Natural		Home	
Signature of Physician		Signature of Registrar		Signature of Coroner		Signature of Medical Examiner		Signature of Funeral Home		Signature of Family	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
Date of Certificate		Date of Burial		Date of Interment		Date of Cremation		Date of Disposition		Date of Return	
8-10-58		8-10-58		8-10-58		8-10-58		8-10-58		8-10-58	

632

50-10353

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50-10353

1. NAME OF DECEASED (Type or Print) BESSIE BRODGEN		2. DATE OF DEATH NOV. 30, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland HAL 4		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY	
5. FULL NAME OF INSTITUTION (If not in hospital or institution, give street address or location) JOHNS HOPKINS HOSPITAL		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE	
c. Length of stay in Baltimore Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) 910 PEACH ST. 23-01	
5. SEX FEMALE	6. COLOR OR RACE COLORED	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH 1892
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (in years last birthday) 58
13. FATHER'S NAME unknown		11. BIRTHPLACE (State or foreign country) md	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		12. CITIZEN OF WHAT COUNTRY?	
16. SOCIAL SECURITY NO.		14. MOTHER'S MAIDEN NAME unknown	
17. INFORMANT JOHNS HOPKINS HOSPITAL		ADDRESS	

18. I 150X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ATELECTASIS FOLLOWING OPERATION FOR CARCINOMA OF ESOPHAGUS	CAUSE OF DEATH Atelectasis following operation for carcinoma of esophagus	INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(A) DUE TO	
	(B) DUE TO	
	(C) DUE TO	

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION Nov 27, 1950	19B. MAJOR FINDINGS OF OPERATION Ca of Esophagus	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH	21B. PLACE OF INJURY (e.g., in about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from 11-16 , 19 50 , to 11-30 , 19 50 , that I last saw the deceased alive on 11-30 , 19 50 , and that death occurred at 3:00 a. m. , from the causes and on the date stated above.		
23A. SIGNATURE J. N. P. John	23B. ADDRESS JOHNS HOPKINS HOSPITAL	23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial	24B. DATE 12/4/50	24C. NAME OF CEMETERY OR CREMATORY Mt Auburn Ct	24D. LOCATION (City, town, or county) (State) Balt City
DATE RECEIVED BY LOCAL REGISTRAR DEC 4-1950	REGISTRAR'S SIGNATURE Wilmington Williams, M.D.	25. FUNERAL DIRECTOR 108-W ADDRESS J. S. Brown & Son - Montgomery St	

50-10353

RECEIVED
FEB 10 1953

50-10353

NOV 2 1952

RECEIVED
FEB 10 1953

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72

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10354

Registered No.

50-10354

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Lucy Virginia Lee

2. DATE
OF
DEATH

12/1/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)

Maryland General Hospital

C. CITY OR TOWN

Baltimore

(If outside corporate limits, write full name and give township)

C. Length of stay in Baltimore

49 years

5. SEX

Female

6. COLOR OR RACE

white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

widowed

8. DATE OF BIRTH

5-17-78

9. AGE (In years last birthday)

72

If Under 1 Year Months Days

If Under 24 Hours Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Isaac Newton Stokes

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, or if unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

Mrs Ozella Petticord

ADDRESS

as above

18. 442X

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(A) Cerebrovascular accident
DUE TO Cerebral arteriosclerosis
(B) Arteriosclerotic cardiovascular disease
DUE TO Renal disease
(C) Hypertensive cerebrovascular disease

INTERVAL BETWEEN ONSET AND DEATH

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11/30, 1950 to 12/1, 1950 that I last saw the deceased alive on 12/1, 1950 and that death occurred at 6:12 p.m., from the causes and on the date stated above.

23A. SIGNATURE

Marguerite Louise Cardley

23B. ADDRESS

Maryland General Hospital

23C. DATE SIGNED

12/1/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

Dec. 4-1950

24C. NAME OF CEMETERY OR CREMATORY

Good Shepherd

24D. LOCATION (City, town, or county) (State)

Howard Co. Maryland

DATE RECEIVED BY LOCAL REGISTRAR

DEC 4-1950

REGISTRAR'S SIGNATURE

Tunington Williams, M.D.

25. FUNERAL DIRECTOR

Burgee Funeral Home 3631 Falls Road

ADDRESS

Anace F. Burgee

131A

30-15354

30-15354



525

-10355

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50-10355

BIRTH NO.

1. NAME OF DECEASED (Type or Print) H. ORTMAN CONZEMAN			2. DATE OF DEATH 11/30/50		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY		
B. FULL NAME OF (If not in hospital or institution, give street address or location) 2803 GARRISON BLVD.			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTO.		
C. Length of stay in Baltimore LIFE			D. STREET ADDRESS (If rural, give location) 1748 MONTEPELIER ST.		
5. SEX M	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) DIVORCED	8. DATE OF BIRTH FEB. 15, 1900	9. AGE (In years last birthday) 50	10. Under 1 Year Months: Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PAINTER			10B. KIND OF BUSINESS OR INDUSTRY SELF EMPLOYED		
11. BIRTHPLACE (State or foreign country) IND.			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME JOHN CONZEMAN			14. MOTHER'S MAIDEN NAME HENRIETTA STUMPF		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) UNKNOWN			16. SOCIAL SECURITY NO.		
17. INFORMANT HENRIETTA CONZEMAN			ADDRESS 1748 MONT-PELIER ST.		

CAUSE OF DEATH

18. 420.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)	(A) Hypertensive Cardiovascular Disease, Coronary	INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES	(B) sclerosis, general sclerosis	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(C) Right Hemiplegia, cerebral hemorrhage	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **Nov. 28**, 19**50**, to **Nov. 30**, 19**50**, that I last saw the deceased alive on **Nov. 30**, 19**50**, and that death occurred at **1 p.m.**, from the causes and on the date stated above.

23A. SIGNATURE **Dr. Frederick R. Rydberg** 23B. ADDRESS **8009 N. Patterson St. Balto. MD.** 23C. DATE SIGNED **12/1/50**

24A. BURIAL, CREMATION, NON-REMOVAL (Specify) BURIAL	24B. DATE 12/4/50	24C. NAME OF CEMETERY OR CREMATORY IMMANUEL CEMT.	24D. LOCATION (City, town, or county) (State) BALTO. MD.
DATE RECEIVED BY LOCAL REGISTRAR DEC 4 - 1950	REGISTRAR'S SIGNATURE Emmington Williams, M.D.	25. FUNERAL DIRECTOR Clarence P. Hoffmann	ADDRESS BROAD 1639 WAY

VS 150

564 24

93D

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

BEFORE ME, the undersigned authority, on this day personally appeared

and acknowledged to me that he was the lawful possessor of the

and that he executed the foregoing instrument for the purposes and

expressed in the instrument.

Given under my hand and seal of office this day of

19

Notary Public in and for the State of

My commission expires this day of

19

Witness my hand and seal of office this day of

19

Notary Public in and for the State of

My commission expires this day of

19

Notary Public in and for the State of

My commission expires this day of

19

Notary Public in and for the State of

My commission expires this day of

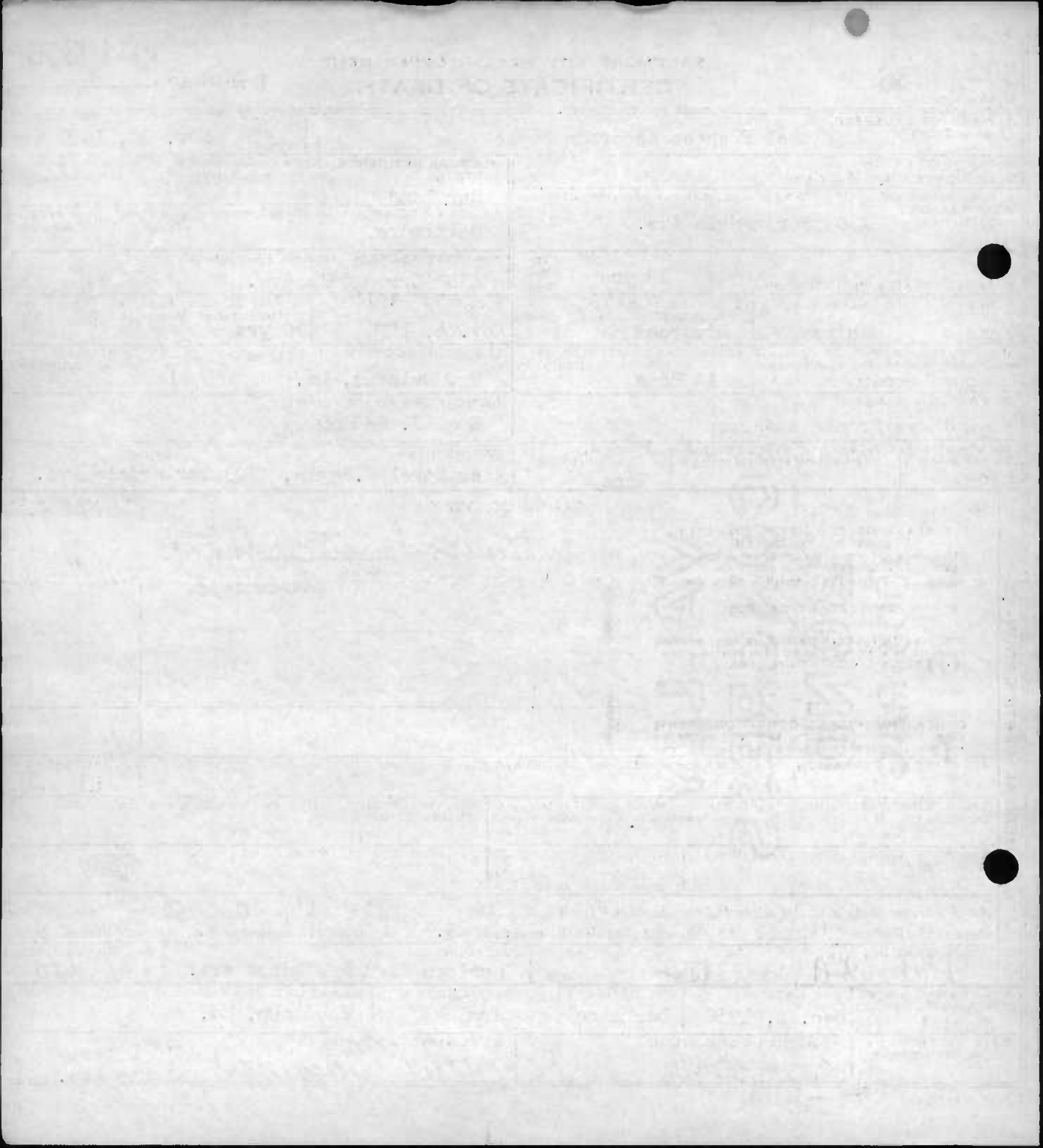
19

400
50-10356BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10356

Registered No.

1. NAME OF DECEASED (Type or Print) Ethel Frances Anderson Boyle		2. DATE OF DEATH Nov. 30, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION 4303 Springdale Ave.		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore	
C. Length of stay in Baltimore 28 yrs Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) 4303 Springdale Ave. 28-02	
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Divorced	8. DATE OF BIRTH Nov. 6, 1880
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper		10B. KIND OF BUSINESS OR INDUSTRY At Home	9. AGE (In years last birthday) 70 yrs
11. BIRTHPLACE (State or foreign country) New Orleans, La.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME James Brooke Anderson		14. MOTHER'S MAIDEN NAME Emma J. Hedden	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Miss Ethel F. Boyle, 4303 Springdale Ave.		ADDRESS	
18. 420.0 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Anterossclerotic heart disease DUE TO (A) Anterossclerotic heart disease (B) DUE TO (C) INTERVAL BETWEEN ONSET AND DEATH 1 1/2 yrs.			
19A. DATE OF OPERATION 0		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 4/25 , 19 39 to 11/30 , 19 50 , that I last saw the deceased alive on 11/30 , 19 50 , and that death occurred at 5.30P m., from the causes and on the date stated above.			
23A. SIGNATURE Robert A. Reiter M. D.		23B. ADDRESS Garrison Blvd & Windsor Ave.	
23C. DATE SIGNED 12/1/50			
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE Dec. 4, 1950	
24C. NAME OF CEMETERY OR CREMATORY Lorraine Cemetery		24D. LOCATION (City, town, or county) (State) Woodlawn, Md.	
DATE RECEIVED BY LOCAL REGISTRAR DEC 4 - 1950		REGISTRAR'S SIGNATURE Wm. Williams, Jr.	
25. FUNERAL DIRECTOR Wm. Williams, Jr.		ADDRESS 4510 Liberty Heights Ave.	



30

CERTIFICATE CORRECTED

1-10-51

50-10357

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

50-10357

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Harvey James Sunday

2. DATE
OF
DEATH

Dec 2 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR INSTITUTION

4713. Gwynn Oak Ave.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Md.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3302 Hillside Road 28-02

c. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Feb. 2 1882

9. AGE (In years
last birthday)

68

If Under 1 Year

Months: Days

If Under 24 Hours

Hours: Min.

10. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Retired Pharmacist

10B. KIND OF BUSINESS OR
INDUSTRY

Drug

11. BIRTHPLACE (State or foreign country)

N.Y.C., Cal.

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Gwynn Sunday

14. MOTHER'S MAIDEN NAME

Hantz

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

Dr. Stuart Sunday

ADDRESS

201 E 33rd St.

18. 420.1 I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A)

DUE TO

coronary thrombosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

coronary arteriosclerosis

3 YRS

II

(C)

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e.g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT ☒ NOT WHILE ☐
WORK AT WORK

22. I hereby certify that I attended the deceased from JAN 1946 to DEC 2, 1950 that I last saw the deceased alive on DEC. 2, 1950 and that death occurred at 5:30 PM from the causes and on the date stated above.

23A. SIGNATURE

Stuart J. Sunday

23B. ADDRESS

201 E 33rd St.

23C. DATE SIGNED

12/1/50

24A. BURIAL, CREMA-
TION (Specify)

Burial

24B. DATE

Dec 5 1950

24C. NAME OF CEMETERY OR CREMATORY

St. Luke's Cemetery

24D. LOCATION (City, town, or county)

Baltimore, Md.

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

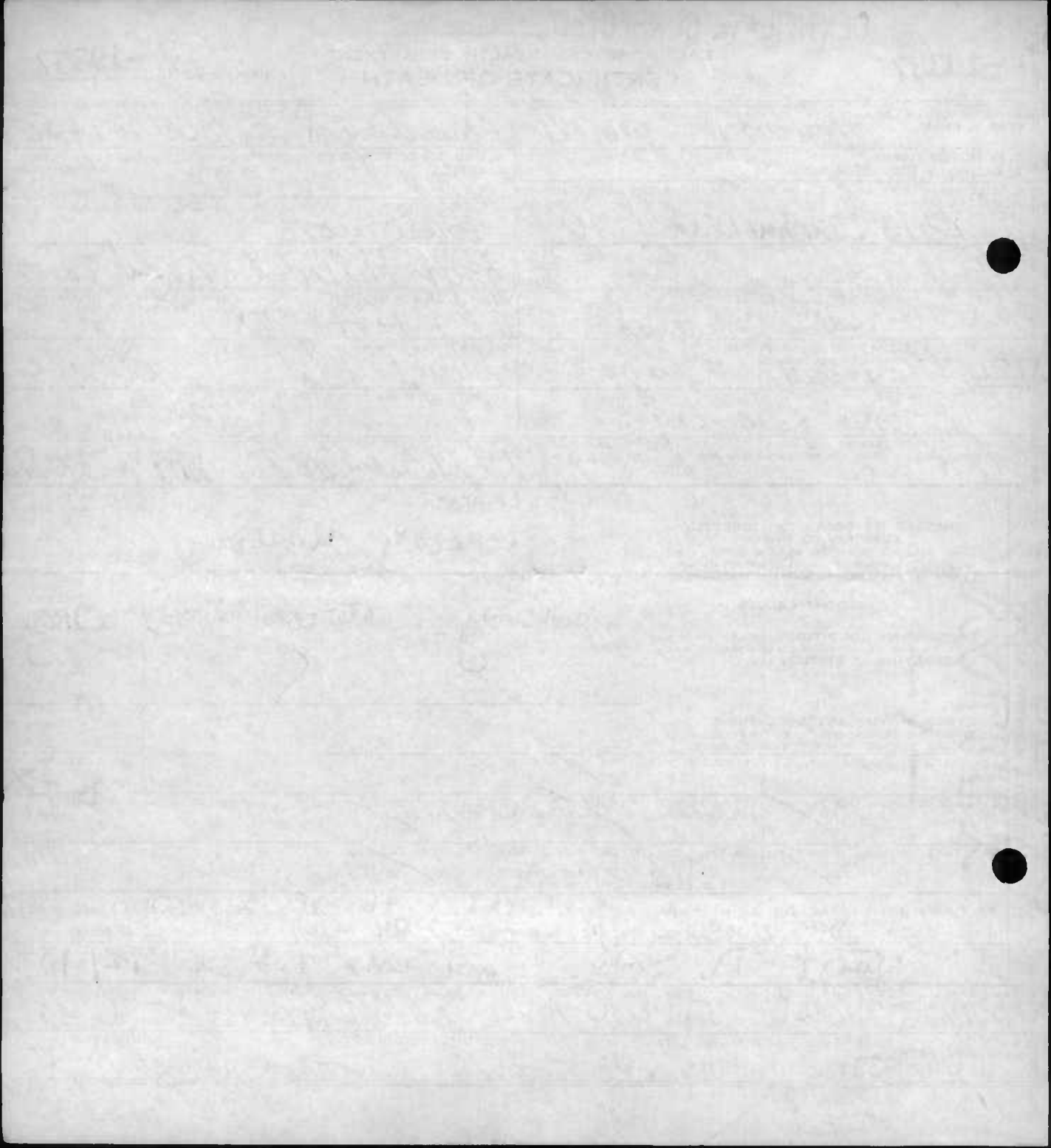
William Williams

25. FUNERAL DIRECTOR

Helen L. Moore 4510 Liberty High

ADDRESS

MEDICAL CERTIFICATION



-62

50-10358

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10358

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

MARY J. LIMERICK

2. DATE
OF
DEATH

Nov. 30/1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence
before admission)

A. STATE

B. COUNTY

MARYLAND

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

320 S. Payson St. 20-03

c. Length of stay in Baltimore

Life

Yrs.
Mos.
Days

5. SEX

Female White

6. COLOR OR RACE

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

9/14/1886

9. AGE in years
last birthday

64

11 Under 1 Year
Months: Days11 Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR
INDUSTRY

At Home

11. BIRTHPLACE (State or foreign country)

Baltimore-Md.

12. CITIZEN OF
WHAT COUNTRY?

USA.

13. FATHER'S NAME

James Munoy

14. MOTHER'S MAIDEN NAME

Mary L.

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

—

17. INFORMANT

ADDRESS

George M. Limerick. - Same

18. 260 X I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A)

Cerebral Embolism

DUE TO

INTERVAL BETWEEN
ONSET AND DEATH

4 days?

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

Auricular Fibrillation

DUE TO

4 yrs.?

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

Diabetes Mellitus & Arterio-
sclerosis - generalized

2 yrs.!

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT ☐ NOT WHILE ☐
WORK WORK AT WORK22. I hereby certify that I attended the deceased from March, 1941 to 11/30, 1950, that I last saw the
deceased alive on 11/30, 1950, and that death occurred at 4:00 p.m., from the causes and on the date stated above.

23A. SIGNATURE

Margaret E. Pogorad

M. D.

23B. ADDRESS

1905 W. Balto. Sr.

23C. DATE SIGNED

12/3/50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

Burial

Dec. 4/1950

Garden Park Cem.

Balto. Md.

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

DEC 4 - 1950

Huntington Williams, M.D.

H. B. Whippert & Son, 1300 E. Main St.

VALLEY

[Faint, illegible text covering the majority of the page, likely bleed-through from the reverse side.]

516
0-10359BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10359

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <i>Anthony Ambrose (Ambrosio)</i>			2. DATE OF DEATH <i>Dec 1 1950</i>		
3. PLACE OF DEATH: A. Baltimore City, Maryland <i>285 Chapel Gate Lane</i>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY		
B. FULL NAME OF HOSPITAL OR INSTITUTION			C. CITY OR TOWN <i>Baltimore</i> If outside corporate limits, write R.R. and give township)		
C. Length of stay in Baltimore <i>51 yrs</i>			D. STREET ADDRESS (If rural, give location) <i>815 Chapel Gate Lane</i>		
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Widowed</i>	8. DATE OF BIRTH <i>June 7 1871</i>	9. AGE (In years last birthday) <i>79</i>	10. Under 1 Year Months Days 11. Under 24 Hours Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Hammering nails</i>			10B. KIND OF BUSINESS OR INDUSTRY <i>Cloth. Mfg.</i>		
13. FATHER'S NAME <i>Ambrose</i>			12. CITIZEN OF WHAT COUNTRY? <i>Lith</i>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)			16. SOCIAL SECURITY NO. <i>213-14-3638</i>		
17. INFORMANT			ADDRESS <i>Same</i>		

18. <i>4221</i>	CAUSE OF DEATH	INTERVAL BETWEEN ONSET AND DEATH <i>2 weeks</i>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) <i>Myocardial degeneration</i> DUE TO <i>& chronic myocarditis</i>	
ANTECEDENT CAUSES	(B) <i>Arteriosclerosis</i> DUE TO	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION <i>0</i>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
O. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>9-21</i> , 19 <i>46</i> to <i>Dec 1</i> , 19 <i>50</i> , that I last saw the deceased alive on <i>Dec 1</i> , 19 <i>50</i> , and that death occurred at <i>4:15 P.M.</i> , from the causes and on the date stated above.					
23A. SIGNATURE <i>John P. Urlock, Jr.</i>		23B. ADDRESS <i>1227 Wash. Blvd</i>		23C. DATE SIGNED <i>12-3-50</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>12/5/50</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Holy Redeemer Cem</i>	
24D. LOCATION (City, town, or county) <i>Belair Md</i>		24E. DATE RECEIVED BY LOCAL REGISTRAR <i>DEC 4 - 1950</i>		24F. REGISTRAR'S SIGNATURE <i>Wilmington Williams, M.D.</i>	
24G. FUNERAL DIRECTOR <i>Joseph Rosemarino</i>		24H. ADDRESS <i>602 Wash.</i>		24I. VS 150	

93D 1850

1952-1953

On the ground (L. ...)
...

21 Apr. 1952

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...

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100 ft

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133
50-10360

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50-10360

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Dominick Doneditis</i>		2. DATE OF DEATH <i>Dec 2 - 1950</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <i>720 Veronica Ave</i>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i>			
B. FULL NAME OF HOSPITAL OR INSTITUTION		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore</i> <i>25-72</i>			
C. Length of stay in Baltimore <i>50 yrs</i>		D. STREET ADDRESS (If rural, give location) <i>720 Veronica Ave</i> <i>VERONICA</i>			
5. SEX <i>male</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>married</i>		8. DATE OF BIRTH <i>Feb. 1876</i>	9. AGE (In years last birthday) <i>74</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Peckham maker</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Cloth Yngg.</i>		11. BIRTHPLACE (State or foreign country) <i>Lith.</i>	
13. FATHER'S NAME <i>Doneditis</i>		12. CITIZEN OF WHAT COUNTRY? <i>?</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Margaretta Doneditis</i>	
18. <i>150X</i>		CAUSE OF DEATH		ADDRESS <i>720 Veronica</i>	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(A) <i>Carcinoma Oesophagus</i>		INTERVAL BETWEEN ONSET AND DEATH <i>4 years</i>	
ANTECEDENT CAUSES		(B)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		DUE TO			
II		(C)			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>1947</i>		19B. MAJOR FINDINGS OF OPERATION <i>Carcinoma Esophagus</i>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>7-24</i> , 19 <i>46</i> , to <i>12-2</i> , 19 <i>50</i> , that I last saw the deceased alive on <i>Dec 2, 1950</i> , and that death occurred at <i>11:58 P. M.</i> , from the causes and on the date stated above.					
23A. SIGNATURE <i>John P. Unlock, Jr.</i>		23B. ADDRESS <i>1227 Wash Blvd</i>		23C. DATE SIGNED <i>12-3-50</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Buried</i>		24B. DATE <i>12/6/50</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Holy Redeemer Cem</i>	
24D. LOCATION (City, town, or county) <i>Baltimore Md</i>		24E. DATE RECEIVED BY LOCAL REGISTRAR <i>DEC 4 - 1950</i>		25. FUNERAL DIRECTOR <i>Joseph Karaman</i>	
24F. ADDRESS <i>602 Wash</i>		VS 150		690 46	

MEDICAL CERTIFICATION

46a 18-2

500
50-10361BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10361

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) PEARL Rahm		2. DATE OF DEATH 12-2-50	
3. PLACE OF DEATH: A. Baltimore City, Maryland Baltr. Md.		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Balt.	
B. FULL NAME OF HOSPITAL OR INSTITUTION Franklin Sq. Hosp.		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 21-02	
C. Length of stay in Baltimore 50 yrs		D. STREET ADDRESS (If rural, give location) 834 Washington Blvd.	
5. SEX F	6. COLOR OR RACE W.	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH 8-22-1899
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10B. KIND OF BUSINESS OR INDUSTRY at home	9. AGE (In years last birthday) 51
11. BIRTHPLACE (State or foreign country) Washington D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME D. Harrison Doffmeyer		14. MOTHER'S MARDEN NAME Carrigan	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. 834 Wash Blvd.	
17. INFORMANT Mr James R. Rahm		ADDRESS 834 Wash Blvd.	

18. **443 X**

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)

(A)

Uremia

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

hypertension

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

Hypertensive heart disease

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m.

WHILE AT WORK ☐NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from **11-23**, 19**50**, to **Dec 2**, 19**50**, that I last saw the deceased alive on **Dec 2**, 19**50**, and that death occurred at **1140 a.m.**, from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

M. O.

Franklin Sq. Hosp. Balt. Md.**12-2-50**

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

10-1-45

RECEIVED THE
10-3-45

10-3-45

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**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

50-10362

Registered No. _____

1. NAME OF DECEASED
(Type or Print)

STANISLAUS MALINSKI

2. DATE
OF
DEATH

December 1, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

Johns Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore

D. STREET ADDRESS (If rural, give location)

838 S. Bond Street

C. Length of stay in Baltimore

38 YRS

Yrs.
Mos.
Days

5. SEX

male

6. COLOR OR RACE

white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

MARRIED

8. DATE OF BIRTH

1873

9. AGE (In years last birthday)

75

10 Under 1 Year
Months: Days

11 Under 24 Hours
Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Poland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

unknown

14. MOTHER'S MAIDEN NAME

unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

HELEN BIELECKI 1740 BANK ST

18. **4221 I**

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) **Generalized arteriosclerotic cardiovascular disease**

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) _____
DUE TO _____
(C) _____

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Inquiry & Inspection thereon and from Autopsy, Inspection or Inquiry the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

William V. Smith

23B. CHIEF MEDICAL EXAMINER.....☐
ASSISTANT MEDICAL EXAMINER.....☒
MEDICAL INVESTIGATOR.....☐

23C. DATE SIGNED

Dec. 2, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify)

BURIAL

24B. DATE

DEC 6 - 1950

24C. NAME OF CEMETERY

ST. STANISLAUS

24D. LOCATION (City, town, or county)

BALTIMORE, Md.

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

William V. Smith

25. FUNERAL DIRECTOR

ADDRESS

George A. Weber

5801-2

RECEIVED

RECEIVED

400
50-10363BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10363

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Joseph Tyler Hill

2. DATE
OF
DEATH

12-4-50

3. PLACE OF DEATH

A. Baltimore City, Maryland Providence Hosp

B. FULL NAME OF
HOSPITAL OR
INSTITUTION (If not in hospital or institution, give street address or location)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Virginia V-43

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Richmond 201

D. STREET ADDRESS (If rural, give location)

1302 Idlewood Ave

c. Length of stay in Baltimore

Six weeks

5. SEX

m

6. COLOR OR RACE

col

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

widowed

8. DATE OF BIRTH

1878

9. AGE (In years
last birthday)

71

If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Preacher

10B. KIND OF BUSINESS OR
INDUSTRY

Pastor of a church

11. BIRTHPLACE (State or foreign country)

Caroline Co. Va

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Samuel Hill

14. MOTHER'S MAIDEN NAME

Susian Payne

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs Fannie Young 315 Lenox Ave. Town

18. 180X I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) DUE TO

Hypertrophoma of

6 mo.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

Kidney & Metastasis

(C)

& Lungs.

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11/29, 1950, to 12/4, 1950, that I last saw the
deceased alive on 12/4, 1950, and that death occurred at 39 m., from the causes and on the date stated above.

23A. SIGNATURE

A. C. Jackson M. D.

23B. ADDRESS

600 N. Arlington

23C. DATE SIGNED

12/4/50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Wilmington Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

George S. Nelson 1303
Prestman St

30-103-3

30-103-3

CONFIDENTIAL - SECURITY INFORMATION

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-614

50-10364-18905

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10364

Registered No.

1. NAME OF DECEASED (Type or Print) GEORGIE LAVERNE WARFIELD			2. DATE OF DEATH December 1, 1950		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY		
B. FULL NAME OF HOSPITAL OR INSTITUTION 1106 Harlem Avenue			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore		
D. STREET ADDRESS (If rural, give location) 1117 Harlem Avenue			E. Length of stay in Baltimore Yrs. Mos. Days		
5. SEX Female	6. COLOR OR RACE Colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH 9/7/50	9. AGE (In years last birthday) 2	10. Under 1 Year Months: Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant			10B. KIND OF BUSINESS OR INDUSTRY		
11. BIRTHPLACE (State or foreign country) Balto. Md.			12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME George Warfield			14. MOTHER'S MAIDEN NAME Mary George		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
17. INFORMANT Mary Warfield, 1117 Harlem Avenue			ADDRESS		

18. 491 X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Bronchopneumonia CAUSE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH (A) Bronchopneumonia (B) (C)		INTERVAL BETWEEN ONSET AND DEATH	
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19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	

22. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE <i>Stanley S. Durlacher</i> M.D.		23B. CHIEF MEDICAL EXAMINER..... ASSISTANT MEDICAL EXAMINER..... MEDICAL INVESTIGATOR.....		23C. DATE SIGNED 12-1-50	
24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE 12/4/50	24C. NAME OF CEMETERY OR CREMATORY mt Auburn	24D. LOCATION (City, town, or county) (State) md.		
DATE RECEIVED BY LOCAL REGISTRAR DEC 4 - 1950		REGISTRAR'S SIGNATURE <i>William H. Williams, M.D.</i>		25. FUNERAL DIRECTOR Mrs. M. Nelson	
		ADDRESS 1313 Prentiss			

107

12001-10051

UNITED STATES DEPARTMENT OF HEALTH, EDUCATION AND WELFARE

OFFICE OF PUBLIC HEALTH AND SAFETY

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-600
50-10365

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10365
Registered No.

BIRTH NO. 50-07676

1. NAME OF DECEASED (Type or Print) MICHAEL MARROW		2. DATE OF DEATH December 1, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION 2221 Ettings Street		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore	
D. LENGTH OF STAY IN BALTIMORE Life		E. STREET ADDRESS (If rural, give location) 2221 Ettings Street	
5. SEX Male	6. COLOR OR RACE Colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH 4/15/50
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10B. KIND OF BUSINESS OR INDUSTRY	
13. FATHER'S NAME Edward Marrow		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Margaret High		ADDRESS 2221 Ettings St	

18. 490X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Pleural effusion ANTECEDENT CAUSES Lobar pneumonia DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Mongolian idiocy	CAUSE OF DEATH (A) Pleural effusion DUE TO (B) Lobar pneumonia DUE TO (C) Mongolian idiocy	INTERVAL BETWEEN ONSET AND DEATH
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19A. DATE OF OPERATION 0		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that I took charge of the remains described above, held an Insp. & Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .				

23A. SIGNATURE Stanley B. Dunlachie		23B. CHIEF MEDICAL EXAMINER..... ASSISTANT MEDICAL EXAMINER..... MEDICAL INVESTIGATOR.....		23C. DATE SIGNED 12-1-50
24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE 12/4/50	24C. NAME OF CEMETERY OR CREMATORY Mt Auburn	24D. LOCATION (City, town, or county) (State) md.	
DATE RECEIVED BY LOCAL REGISTRAR DEC 4 - 1950	REGISTRAR'S SIGNATURE William H. Williams		25. FUNERAL DIRECTOR Geo. S. Kelson ADDRESS 1303 108 Presstman	

CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age	
4. Date of death		5. Time of death		6. Place of death	
7. Cause of death		8. Manner of death		9. Signature of physician	
10. Signature of registrar		11. Signature of informant		12. Signature of witness	
13. Signature of undertaker		14. Signature of funeral home		15. Signature of cemetery	
16. Signature of church		17. Signature of family		18. Signature of neighbors	
19. Signature of friends		20. Signature of community		21. Signature of society	
22. Signature of association		23. Signature of organization		24. Signature of institution	
25. Signature of government		26. Signature of state		27. Signature of federal	
28. Signature of international		29. Signature of world		30. Signature of universe	
31. Signature of everything		32. Signature of nothing		33. Signature of somewhere	
34. Signature of nowhere		35. Signature of when		36. Signature of how	
37. Signature of why		38. Signature of what		39. Signature of who	
40. Signature of which		41. Signature of whom		42. Signature of whose	
43. Signature of what		44. Signature of where		45. Signature of when	
46. Signature of how		47. Signature of why		48. Signature of what	
49. Signature of who		50. Signature of which		51. Signature of whom	
52. Signature of whose		53. Signature of what		54. Signature of where	
55. Signature of when		56. Signature of how		57. Signature of why	
58. Signature of what		59. Signature of who		60. Signature of which	
61. Signature of whom		62. Signature of whose		63. Signature of what	
64. Signature of where		65. Signature of when		66. Signature of how	
67. Signature of why		68. Signature of what		69. Signature of who	
70. Signature of which		71. Signature of whom		72. Signature of whose	
73. Signature of what		74. Signature of where		75. Signature of when	
76. Signature of how		77. Signature of why		78. Signature of what	
79. Signature of who		80. Signature of which		81. Signature of whom	
82. Signature of whose		83. Signature of what		84. Signature of where	
85. Signature of when		86. Signature of how		87. Signature of why	
88. Signature of what		89. Signature of who		90. Signature of which	
91. Signature of whom		92. Signature of whose		93. Signature of what	
94. Signature of where		95. Signature of when		96. Signature of how	
97. Signature of why		98. Signature of what		99. Signature of who	
100. Signature of which		101. Signature of whom		102. Signature of whose	
103. Signature of what		104. Signature of where		105. Signature of when	
106. Signature of how		107. Signature of why		108. Signature of what	
109. Signature of who		110. Signature of which		111. Signature of whom	
112. Signature of whose		113. Signature of what		114. Signature of where	
115. Signature of when		116. Signature of how		117. Signature of why	
118. Signature of what		119. Signature of who		120. Signature of which	
121. Signature of whom		122. Signature of whose		123. Signature of what	
124. Signature of where		125. Signature of when		126. Signature of how	
127. Signature of why		128. Signature of what		129. Signature of who	
130. Signature of which		131. Signature of whom		132. Signature of whose	
133. Signature of what		134. Signature of where		135. Signature of when	
136. Signature of how		137. Signature of why		138. Signature of what	
139. Signature of who		140. Signature of which		141. Signature of whom	
142. Signature of whose		143. Signature of what		144. Signature of where	
145. Signature of when		146. Signature of how		147. Signature of why	
148. Signature of what		149. Signature of who		150. Signature of which	
151. Signature of whom		152. Signature of whose		153. Signature of what	
154. Signature of where		155. Signature of when		156. Signature of how	
157. Signature of why		158. Signature of what		159. Signature of who	
160. Signature of which		161. Signature of whom		162. Signature of whose	
163. Signature of what		164. Signature of where		165. Signature of when	
166. Signature of how		167. Signature of why		168. Signature of what	
169. Signature of who		170. Signature of which		171. Signature of whom	
172. Signature of whose		173. Signature of what		174. Signature of where	
175. Signature of when		176. Signature of how		177. Signature of why	
178. Signature of what		179. Signature of who		180. Signature of which	
181. Signature of whom		182. Signature of whose		183. Signature of what	
184. Signature of where		185. Signature of when		186. Signature of how	
187. Signature of why		188. Signature of what		189. Signature of who	
190. Signature of which		191. Signature of whom		192. Signature of whose	
193. Signature of what		194. Signature of where		195. Signature of when	
196. Signature of how		197. Signature of why		198. Signature of what	
199. Signature of who		200. Signature of which		201. Signature of whom	
202. Signature of whose		203. Signature of what		204. Signature of where	
205. Signature of when		206. Signature of how		207. Signature of why	
208. Signature of what		209. Signature of who		210. Signature of which	
211. Signature of whom		212. Signature of whose		213. Signature of what	
214. Signature of where		215. Signature of when		216. Signature of how	
217. Signature of why		218. Signature of what		219. Signature of who	
220. Signature of which		221. Signature of whom		222. Signature of whose	
223. Signature of what		224. Signature of where		225. Signature of when	
226. Signature of how		227. Signature of why		228. Signature of what	
229. Signature of who		230. Signature of which		231. Signature of whom	
232. Signature of whose		233. Signature of what		234. Signature of where	
235. Signature of when		236. Signature of how		237. Signature of why	
238. Signature of what		239. Signature of who		240. Signature of which	
241. Signature of whom		242. Signature of whose		243. Signature of what	
244. Signature of where		245. Signature of when		246. Signature of how	
247. Signature of why		248. Signature of what		249. Signature of who	
250. Signature of which		251. Signature of whom		252. Signature of whose	
253. Signature of what		254. Signature of where		255. Signature of when	
256. Signature of how		257. Signature of why		258. Signature of what	
259. Signature of who		260. Signature of which		261. Signature of whom	
262. Signature of whose		263. Signature of what		264. Signature of where	
265. Signature of when		266. Signature of how		267. Signature of why	
268. Signature of what		269. Signature of who		270. Signature of which	
271. Signature of whom		272. Signature of whose		273. Signature of what	
274. Signature of where		275. Signature of when		276. Signature of how	
277. Signature of why		278. Signature of what		279. Signature of who	
280. Signature of which		281. Signature of whom		282. Signature of whose	
283. Signature of what		284. Signature of where		285. Signature of when	
286. Signature of how		287. Signature of why		288. Signature of what	
289. Signature of who		290. Signature of which		291. Signature of whom	
292. Signature of whose		293. Signature of what		294. Signature of where	
295. Signature of when		296. Signature of how		297. Signature of why	
298. Signature of what		299. Signature of who		300. Signature of which	

415
0-10366

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10366
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Walter Sullivan

2. DATE
OF
DEATH

12/1/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

MD

B. COUNTY

before admission)

B. FULL NAME OF (If not in hospital or institution, give street address or location)

21. 17

C. CITY OR TOWN

Baltimore

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

1700 Linden Ave

E. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

M

6. COLOR OR RACE

C

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

1883

9. AGE (in years
last birthday)

67

If Under 1 Year
Months: Days

If Under 24 Hours
Hours: Min.

10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

MD

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Bldg. Operator

14. MOTHER'S MAIDEN NAME

George

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

18. 600.0

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e. g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A)

Chronic Pyelonephritis

9 yrs

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

Bilateral intramural
ureteral obstruction, congenital

(C)

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

Diabetes Mellitus

9 yrs

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE
WORK AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12/1, 1950, to 12/1, 1950, that I last saw the
deceased alive on 12/1, 1950, and that death occurred at 9:15 P.M., from the causes and on the date stated above.

23A. SIGNATURE

E. O. Hane

M. D.

23B. ADDRESS

U. H.

23C. DATE SIGNED

12/2/50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

Burial

12/5/50

Int Calvary

MD

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

DEC 4-1950

Wm. H. Williams, Jr.

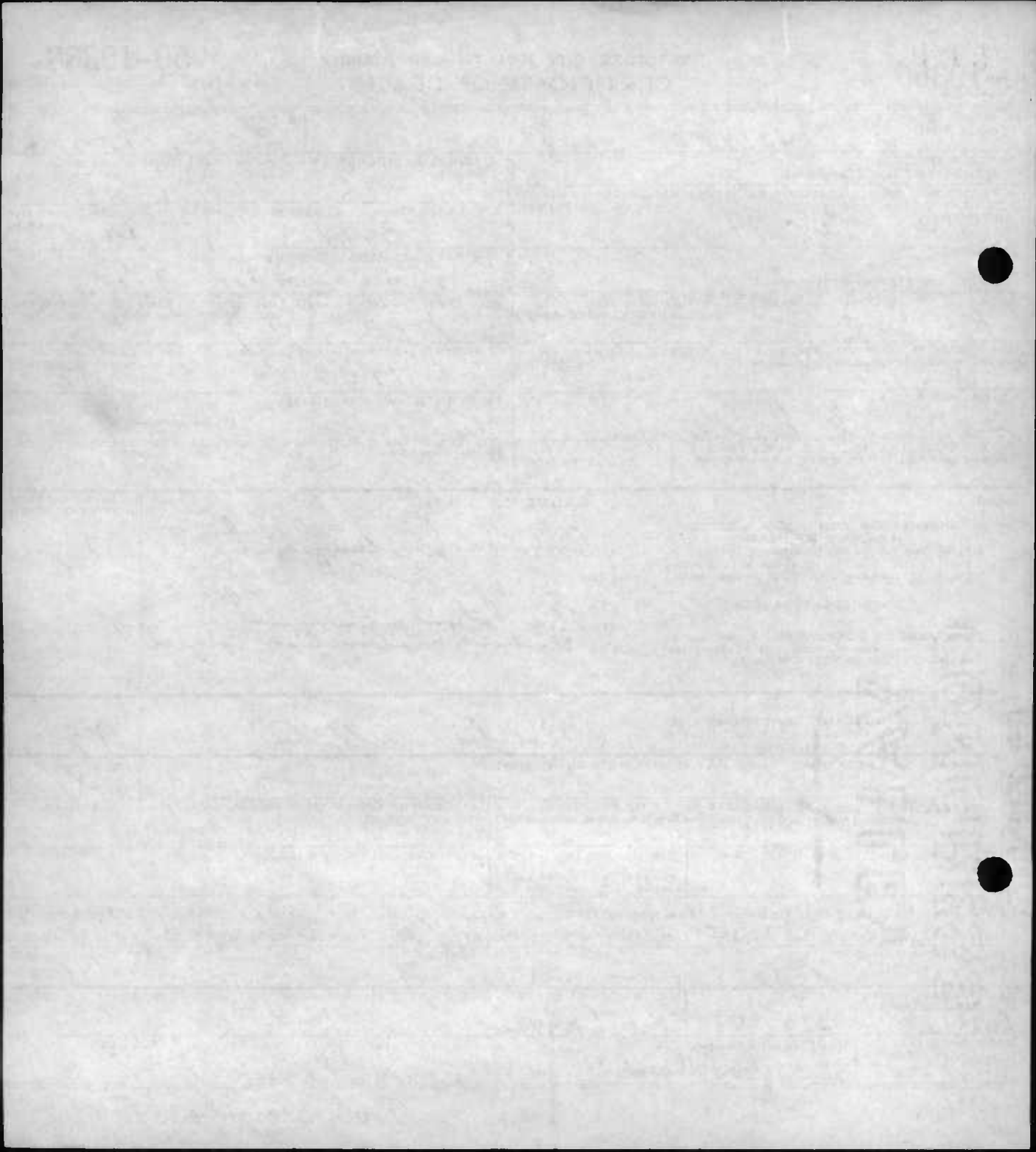
Geo. H. Nelson

1303

VS 150

77074

Prestman St 61



656
50-10367BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50-10367
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

CARRIE A WARNER

2. DATE
OF
DEATH

Dec 3, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION

826 W. 35th St

Yrs.
Mos.
Days

C. Length of stay in Baltimore

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Md.

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Balto.

D. STREET ADDRESS (If rural, give location)

826 W. 35th St.

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Divorced

8. DATE OF BIRTH

Oct 30, 1890

9. AGE (in years
last birthday)

60

10 Under 1 Year
Months: Days10 Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Saleslady

10B. KIND OF BUSINESS OR
INDUSTRY

Brager Dept Store

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

?

14. MOTHER'S MAIDEN NAME

?

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

—

—

16. SOCIAL
SECURITY NO.

218-01-0663

17. INFORMANT

ADDRESS

Cather P. Warner 826 W. 35th St.

18. 163X I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A) Carcinoma Pulmonary

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

INTERVAL BETWEEN
ONSET AND DEATHII
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE
WORK AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the
deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.

23A. SIGNATURE

M. D.

23B. ADDRESS

1123 St Paul St

23C. DATE SIGNED

12-4-50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

12/6/50

24C. NAME OF CEMETERY OR CREMATORY

Parkwood

24D. LOCATION (City, town, or county)

Parkville, Md.

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

DEC 4 - 1950

William H. Williams, Jr.

Paul C. Schenck, Jr. 3615 N. Calhoun Ave.

VS 150

490 6C

47D

MEDICAL CERTIFICATION

1123 St Paul St.

8-452

50-10368

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10368

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

CLARA BROWN COLLINS

2. DATE
OF
DEATH

12-2-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION

819 N. EDEN ST.

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)
A. STATE

Md.

B. COUNTY

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

BALTIMORE

D. STREET ADDRESS (If rural, give location)

819 N. EDEN ST.

c. Length of stay in Baltimore

Life

Yrs.
Mos.
Days

5. SEX

F

6. COLOR OR RACE

C.

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

WIDOW

8. DATE OF BIRTH

10-4-1884

9. AGE (In years
last birthday)

66

If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR
INDUSTRY

Housewife

11. BIRTHPLACE (State or foreign country)

Md

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

?

14. MOTHER'S MAIDEN NAME

DORIS MATHENIS

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

MAMIE COLLINS 819 N. EDEN

18. 332X

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A)

Cerebral Thrombosis

INTERVAL BETWEEN
ONSET AND DEATH

3 weeks

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

Arteriosclerosis

?

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
INJURY

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept 5, 1949 to Dec 2, 1949 that I last saw the
deceased alive on Dec 1, 1949 and that death occurred at 4:10 p.m., from the causes and on the date stated above.

23A. SIGNATURE

F. K. Adams

23B. ADDRESS

12222 Caroline St

23C. DATE SIGNED

12-4-50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

BURIAL

24B. DATE

12-6-50

24C. NAME OF CEMETERY OR CREMATORY

Mt. CALVARY

24D. LOCATION (City, town, or county)

A. A. COUNTY Md.

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Wilmington Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

Joseph B. Lock, Jr. 1304 N. Central Ave

DEC 4 - 1950
VS 150

83B

MEDICAL CERTIFICATION

B-652
50-10369BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50-10369
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

MARTIN J. BURNS

2. DATE
OF
DEATH

1 Dec, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

Union Memorial Hospital

Yrs.
Mos.
Days

C. Length of stay in Baltimore

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

B. COUNTY

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

435 E. 27th St.

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years last birthday)

If Under 1 Year
Months: Days
If Under 24 Hours
Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Dishwasher

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Ireland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Daniel Burns

Rev.

14. MOTHER'S MAIDEN NAME

Mary Sharkey

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

Unknown

16. SOCIAL SECURITY NO.

17. INFORMANT

P & B wife

ADDRESS

18. 4201

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) MYOCARDIAL INFARCTION

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) CORONARY OCCLUSION

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

PULMONARY INFARCTIONS, BILATERAL

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) INJURY

21E. INJURY OCCURRED

m.

WHILE AT WORK ☐NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 29 Nov., 1950, to 1 Dec., 1950 that I last saw the deceased alive on 1 Dec., 1950, and that death occurred at 11:05 A.M., from the causes and on the date stated above.

23A. SIGNATURE

Richard Brown

23B. ADDRESS

M. D.

Union Memorial Hospital

23C. DATE SIGNED

12-1-50

24A. BURIAL, CREMATION, REMOVAL (Specify)

BURIAL

24B. DATE

12-4-50

24C. NAME OF CEMETERY OR CREMATORY

CATHEDRAL

24D. LOCATION (City, town, or county)

CITY

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Wilmington Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

Greensward Ave 22nd St

VS 150

790 6M

DEC 4 - 1950

10-10-59

10-10-59

MARTIN J. FORD

102 E. 22nd St.

102 E. 22nd St.

U.S.A.

102 E. 22nd St.

102 E. 22nd St.

102 E. 22nd St.

102 E. 22nd St.

102 E. 22nd St.

M-250

50-10370

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10370

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

JOSEPHINE MASON

2. DATE
OF
DEATH

12/2/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION

932 Madison Ave

Yrs.
Mos.
Days

C. Length of stay in Baltimore

30 yrs

5. SEX

F

6. COLOR OR RACE

C

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

March 1878

9. AGE (In years,
last birthday)

72

10. Under 1 Year
Months: Days11. Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

John Bernard

14. MOTHER'S MAIDEN NAME

?

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Jessie Mason 932 Madison St

18. 334X

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A)

DUE TO

Apoplexy -

INTERVAL BETWEEN
ONSET AND DEATH

3 days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

Arteriosclerosis

1 year

(C)

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)
INJURY

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11/29/1950 to 12/2/1950, that I last saw the
deceased alive on 12/2/1950, and that death occurred at 5:30 P. M., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

J. H. Harkins

M. D.

450 W. Biddle St

12/4/50

24A. BURIAL, CREMA-
TION REMOVAL (Specify)

24B. DATE

24C. NAME OF SEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

DEC 4-1950

C. H. Williams, M.D.

J. A. Halstead 918 S. 83rd Ave

10-10340

RECEIVED
FEDERAL BUREAU OF INVESTIGATION
U. S. DEPARTMENT OF JUSTICE

10-10340

10/10/50

JOSEPHINE MASON

Red

10-10340

10-10340

10-10340

10-10340

10-10340

10-10340

10-10340

10-10340

10-10340

10-10340

10-10340

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10-10340

10-10340

10-10340

G-164
50-10371BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50-10371
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) SANTA GABRIELE		2. DATE OF DEATH December 2 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MARYLAND B. COUNTY	
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION 213 S. Exeter STREET		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE 3-02	
C. Length of stay in Baltimore 36 Yrs. Mos? Days		D. STREET ADDRESS (If rural, give location) 213 S. Exeter Street	
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH 3 November, 1888
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Home	9. AGE (In years last birthday) 62
11. BIRTHPLACE (State or foreign country) ITALY		12. CITIZEN OF WHAT COUNTRY? ITALY ✓	
13. FATHER'S NAME PASQUALE MARINELLI		14. MOTHER'S MAIDEN NAME ROSE SANTUCCI	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.	
17. INFORMANT MR BEARD, Gabriele, 2133 Exeter		ADDRESS	

18. 157X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CANCER OF PANCREAS with 9 months DUE TO SPREAD TO liver and intestines	CAUSE OF DEATH	INTERVAL BETWEEN ONSET AND DEATH
19. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. BRONCHOPNEUMONIA	ANTecedent CAUSES	24 days

19A. DATE OF OPERATION 0		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED m. WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from June 1, 1947 , to Dec. 2, 1950 , that I last saw the deceased alive on Dec 2, 1950 , and that death occurred at 4:10 P.m. , from the causes and on the date stated above.					
23A. SIGNATURE William N. Borden M.D.		23B. ADDRESS 2030 W. Fayette		23C. DATE SIGNED 12/2/50	
24A. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24B. DATE DEC. 6 1950		24C. NAME OF CEMETERY OR CREMATORY HOLY REDEEMER	
24D. LOCATION (City, town, or county) (State) 4430 BELAIR RD BAL. MD.		25. FUNERAL DIRECTOR Frank Della Noce 322 S. HIGH ST.			
26. LOCAL REGISTRAR C 4-1950		27. REGISTRAR'S SIGNATURE William N. Borden		28. ADDRESS	

10-10-1914

CERTIFICATE OF DEATH

10-10-1914

During Dec 6 1920 Holy Redeemer
4430 Federal RD Bar No
Lambert Ave 3rd 2 West 21

R-245
50-10372BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50-10372
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) CATHERINE REUSCHLIN (REUSCHLING)			2. DATE OF DEATH December 1, 1950		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY		
B. FULL NAME OF (If not in hospital or institution, give street address or location) South Baltimore General Hospital			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 23-01		
D. STREET ADDRESS (If rural, give location) 1006 Hanover Street					
5. SEX female			6. COLOR OR RACE white		
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) W			8. DATE OF BIRTH 6/22/1879 1859		
9. AGE (In years last birthday) 91			10. Under 1 Year Months Days		
11. BIRTHPLACE (State or foreign country) Baltimore			12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME Unknown			14. MOTHER'S MAIDEN NAME Unknown		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, or or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO.		
17. INFORMANT Family - Same			ADDRESS		

18. 4221 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease DUE TO (A)		INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (B)		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. DUE TO (C)		

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	

22. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE William H. Smith		23B. CHIEF MEDICAL EXAMINER..... M.D. ASSISTANT MEDICAL EXAMINER..... MEDICAL INVESTIGATOR.....		23C. DATE SIGNED Dec. 2, 1950	
24A. BURIAL, CREMATION, REMOVAL (Specify) B		24B. DATE 12/5/50		24C. NAME OF CEMETERY OR CREMATORY Mt. Olivet	
24D. LOCATION (City, town, or county) Baltimore					

DATE RECEIVED BY LOCAL REGISTRAR DEC 4 - 1950		REGISTRAR'S SIGNATURE William H. Smith		25. FUNERAL DIRECTOR James L. Lee		ADDRESS - 130 E. Fort Ave.	
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V-453

CERTIFICATE CORRECTED
CERTIFICATE CORRECTED

12-4-50

12-5-50

BALTIMORE CITY HEALTH DEPARTMENT

50-10373

CERTIFICATE OF DEATH

Registered No. 50-10373

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

CLYDE V. VALENTINE

2. DATE
OF
DEATH

November 29, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION

St. Joseph's Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence
A. STATE B. COUNTY before admission)

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1919 Greenmount Avenue

Length of stay in Baltimore

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

1893
Feb. 8, 18929. AGE (In years
last birthday)

58 37

If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Engineer & Fireman

10B. KIND OF BUSINESS OR
INDUSTRY

Western Maryland R.

11. BIRTHPLACE (State or foreign country)

Richmond, Virginia

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.
705-10-9171

17. INFORMANT

ADDRESS

Mrs. Elizabeth Valentine Pritz

18. 422.1

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular

~~MYOCARDIAL~~ disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE
WORK AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy thereon and from
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,
and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

Stanley H. Deanecker M.D.

23B. CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED

Nov. 30, 1950

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

Dec 4, 1950

24C. NAME OF CEMETERY OR CREMATORY

Greenmount ac

24D. LOCATION (City, town, or county)

Balto-Md.

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Washington Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

Joseph Forace, Inc.

10-10-13

DEPARTMENT OF DEATH

10-10-13

10-10-13

10-10-13

C-550
50-10374

50-10374

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED
(Type or Print)

HENRY MONROE CANNON

2. DATE
OF
DEATH

Dec. 2, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF
HOSPITAL OR
INSTITUTION (If not in hospital or institution, give street address or location)

2143 Homewood Ave.

Yrs.
Mos.
Days

C. Length of stay in Baltimore

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE
Md.

B. COUNTY

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2143 Homewood Ave.

5. SEX

male

6. COLOR OR RACE

white

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

married

8. DATE OF BIRTH

Aug. 31, 1871

9. AGE (In years
last birthday)

79

If Under 1 Year
Months: Days Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Restauranteer (-td)

10B. KIND OF BUSINESS OR
INDUSTRY

Restaurant

11. BIRTHPLACE (State or foreign country)

Delaware

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Bartholomew Cannon

14. MOTHER'S MAIDEN NAME

Margaret Cannon

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Dr. Bu-delle S. Cannon 5809 Kipping Ct.

1B. 420.1

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A)

DUE TO

Coronary Occlusion

INTERVAL BETWEEN
ONSET AND DEATH

Minutes

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

Arteriosclerosis

?

(C)

Heart Block

5 weeks

II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m.

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐22. I hereby certify that I attended the deceased from Sept., 1950, to Dec., 1950, that I last saw the
deceased alive on Nov. 26, 1950, and that death occurred at 10 A. M., from the causes and on the date stated above.

23A. SIGNATURE

M. D.

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

12/5/50

24C. NAME OF CEMETERY OR CREMATORY

Greenmount Maus.

24D. LOCATION (City, town, or county)

(State)

Balto., Md.

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

DEC 4 - 1950

VS 150

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H-252
50-10375BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10375

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) RICHARD OSBORN HAWKINS			2. DATE OF DEATH Dec. 3, 1950		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY		
B. FULL NAME OF HOSPITAL OR INSTITUTION Doctors Hospital			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 18-02		
c. Length of stay in Baltimore Yrs. Mos. Days			D. STREET ADDRESS (If rural, give location) 1050 W. Baltimore St.		
5. SEX male	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) single	8. DATE OF BIRTH Mar. 12, 1890	9. AGE (in years last birthday) 60	If Under 1 Year Months Days If Under 24 Hours Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Real Estate (Rtd)			11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Joshua E. Hawkins			14. MOTHER'S MAIDEN NAME Mary R. Sheckells		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS Mr. Harold Kaufman - 1229 Munsey Bldg.		

18. 5810	CAUSE OF DEATH	INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)	(A) Cirrhosis of the Liver DUE TO Chronic Alcoholism	6 months
ANTECEDENT CAUSES	(B)	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO	
	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION 0	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDER- LYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED m. WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov. 25, 1950 to Dec. 3, 1950, that I last saw the deceased alive on Dec. 2, 1950, and that death occurred at 2:30 A. M., from the causes and on the date stated above.

23A. SIGNATURE Albert Kermisch	23B. ADDRESS M. D. 1934 Wilkens Avenue	23C. DATE SIGNED DEC 4 1950
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24A. BURIAL, CREMATION, REMOVAL (Specify) Burial	24B. DATE 12/6/50	24C. NAME OF CEMETERY OR CREMATORY Druid Ridge Cem.	24D. LOCATION (City, town, or county) (State) Pikesville, Md.
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DATE RECEIVED BY LOCAL REGISTRAR DEC 4 - 1950	REGISTRAR'S SIGNATURE Huntington Williams, M.D.	25. FUNERAL DIRECTOR Wm. J. Pickner & Sons	ADDRESS 124a Balto, Md.
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1. The first part of the report is a general description of the project. It includes the title, the purpose of the study, and the scope of the work. The title is "A Study of the Effect of Temperature on the Rate of Reaction of Hydrogen Peroxide with Potassium Iodate." The purpose of the study is to determine the effect of temperature on the rate of reaction. The scope of the work is to study the reaction at temperatures ranging from 10°C to 50°C.

2. The second part of the report is a description of the experimental procedure. It includes the materials used, the apparatus, and the method of carrying out the experiment. The materials used are hydrogen peroxide, potassium iodate, and sulfuric acid. The apparatus consists of a reaction flask, a thermometer, and a stopper. The method of carrying out the experiment is to mix the hydrogen peroxide and potassium iodate solutions in the reaction flask, add the sulfuric acid, and measure the time taken for the reaction to complete.

3. The third part of the report is a description of the results of the experiment. It includes a table of the data obtained and a graph showing the effect of temperature on the rate of reaction. The data obtained is as follows:

Temperature (°C)	Time taken for reaction to complete (s)
10	120
20	60
30	30
40	15
50	8

The graph shows that the rate of reaction increases as the temperature increases. This is because the molecules have more energy at higher temperatures and are therefore more likely to collide and react.

4. The fourth part of the report is a discussion of the results. It includes a comparison of the results with those obtained by other workers and a conclusion. The results obtained in this experiment are in good agreement with those obtained by other workers. The conclusion is that the rate of reaction of hydrogen peroxide with potassium iodate increases as the temperature increases.

5. The fifth part of the report is a list of references. It includes the names of the workers whose work has been cited in the report.

6. The sixth part of the report is a list of symbols and abbreviations. It includes the symbols used in the report and their meanings.

7. The seventh part of the report is a list of acknowledgments. It includes the names of the people who have helped in the work.

8. The eighth part of the report is a list of appendices. It includes the names of the appendices and their contents.

9. The ninth part of the report is a list of footnotes. It includes the names of the footnotes and their contents.

10. The tenth part of the report is a list of references. It includes the names of the workers whose work has been cited in the report.

**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

50-10376
Registered No.

BIRTH NO. 50-06513

1. NAME OF DECEASED (Type or Print) <i>ERON Quisenberry</i>		2. DATE OF DEATH <i>Dec 3, 1950</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <i>Baltimore</i>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Baltimore, MD</i> B. COUNTY	
5. FULL NAME OF HOSPITAL OR INSTITUTION <i>Mercy Hosp. & L</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore, MD 12-02</i>	
c. Length of stay in Baltimore <i>Life 8</i>		D. STREET ADDRESS (If rural, give location) <i>1225 N. Phoenix St</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>single</i>	8. DATE OF BIRTH <i>March 26, 1950</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>infant</i>		10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Baltimore</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>ARNO 1st Quisenberry</i>		14. MOTHER'S MAIDEN NAME <i>Mary Lucille Humphreys</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT		ADDRESS	

18. <i>340.0</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	CAUSE OF DEATH <i>Influenza</i> <i>Spontaneous</i>	INTERVAL BETWEEN ONSET AND DEATH (over) <i>4 days</i>
ANTECEDENT CAUSES		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION <i>0</i>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?			

22. I hereby certify that I attended the deceased from *Dec 3, 1950*, to *Dec 3, 1950*, that I last saw the deceased alive on *Dec 3, 1950* and that death occurred at *5:30 p.m.*, from the causes and on the date stated above.

23A. SIGNATURE <i>Mr. McHums</i>	M. D.	23B. ADDRESS <i>Mercy Hospital</i>	23C. DATE SIGNED <i>Dec 3, 1950</i>
-------------------------------------	-------	---------------------------------------	--

24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>	24B. DATE <i>12-4-50</i>	24C. NAME OF CEMETERY OR CREMATORY <i>Thorn Spring</i>	24D. LOCATION (City, town, or county) (State) <i>Pulaski, Va.</i>
DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE <i>William Williams, M.D.</i>	25. FUNERAL DIRECTOR <i>Wm Cook Inc</i>	
		ADDRESS <i>1217 St Paul</i>	

DEC 4 - 1950

8/a

MEDICAL CERTIFICATION

Bureau of Communicable Diseases contacted
doctor at Mercy Hospital who stated
that meningitis was influenzal not spinal.

12/4/50 ES

P-300
50-10377

50-10377

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

MARY PEED

2. DATE
OF
DEATH

12-3-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION

University Hospital

C. Length of stay in Baltimore

Yrs.
Mos.
Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

B. COUNTY

before admission)

Md

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore 10-02

D. STREET ADDRESS (If rural, give location)

834 Abbott St. E.T.

5. SEX

F

6. COLOR OR RACE

W

7. SINGLE MARRIED.

WIDOWED DIVORCED (Specify)

8. DATE OF BIRTH

Mar. 16, 1855

9. AGE (In years
last birthday)

95

If Under 1 Year
Months DaysIf Under 24 Hours
Hours Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

None

10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

William Carter

14. MOTHER'S MAIDEN NAME

Eliza Magniss

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Caroline Willmer, 834 Abbott St.

18. 4500 and E90710

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A)

Arterio sclerosis

DUE TO

generalized

ANTECEDENT CAUSES

(B)

Senility

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

DUE TO

(C)

Several decubitus ulcers

CERTIFICATION APPROVED BY

II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

Fracture of femoral neck

M. D.

19A. DATE OF OPERATION

11-2-50

19B. MAJOR FINDINGS OF OPERATION

Fracture of femoral neck

SELF OR ASST. MEDICAL EXAMINER?

YES ☐ NO ☒21A. ACCIDENT WAS UNDER-
LYING OR CONTRIBUTING
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)

HOME

21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)

834 ABBOT COURT

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

10 31 50 ? m.

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

FELL OUT OF BED

22. I hereby certify that I attended the deceased from 11-1, 1950, to 12-3, 1950 that I last saw the
deceased alive on 12-3, 1950 and that death occurred at 2:40 P.M., from the causes and on the date stated above.

23A. SIGNATURE

E. W. Demarest M. D.

23B. ADDRESS

University Hosp.

23C. DATE SIGNED

12-3-50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

12/6/50

24C. NAME OF CEMETERY OR CREMATORY

Mrs. Oliver Cemetery

24D. LOCATION (City, town, or county)

Baltimore, Md.

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

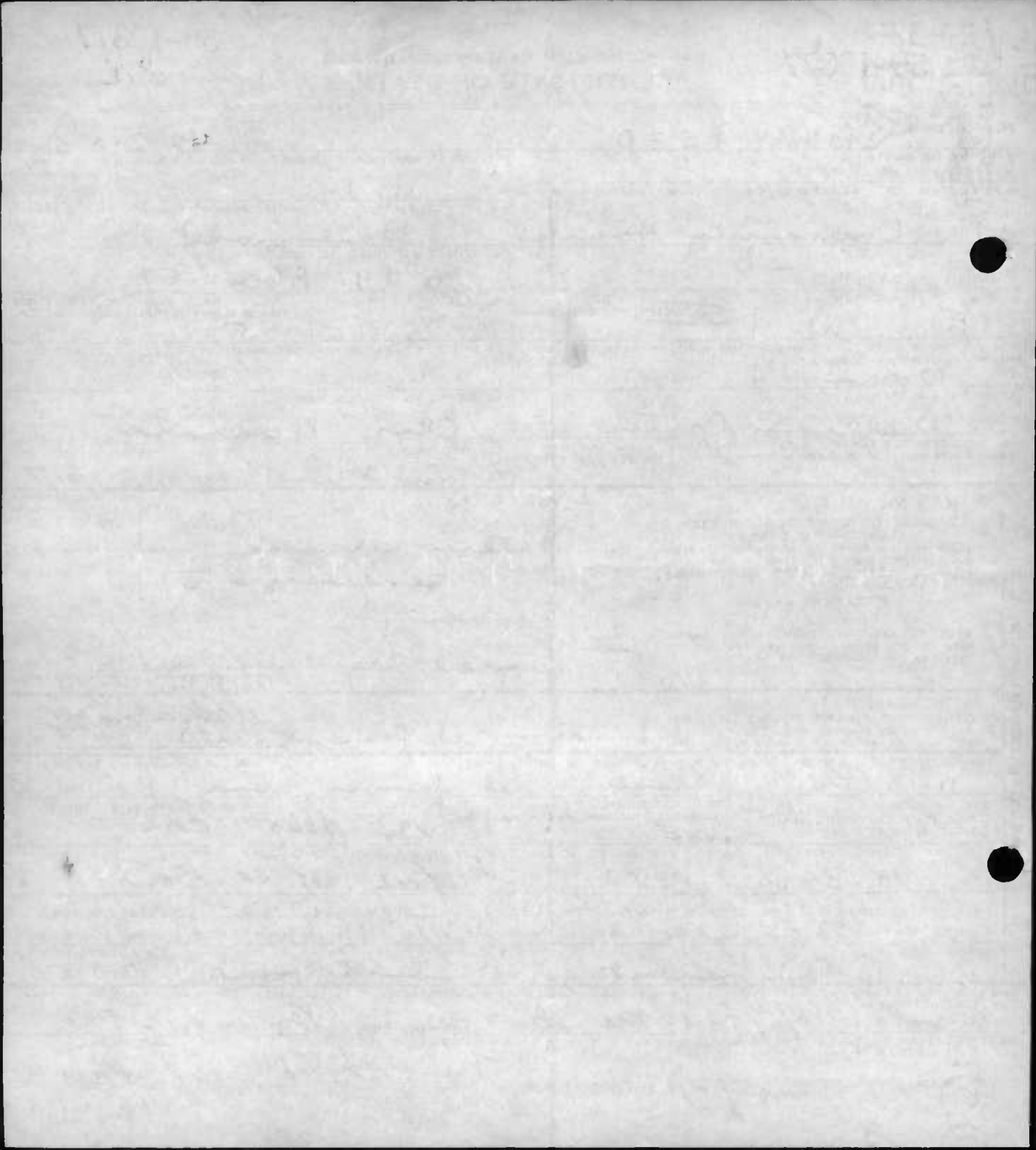
ADDRESS

Wm. Cook, Inc. 1217 E. Paul St.

DEC 4 1950

Washington Williams, M.D.

186a



R-240

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10378

Registered No.

50-10378

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

MARY A. RUSSELL

2. DATE
OF
DEATH

DEC. 2, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)

5207 YORK RD.

C. CITY OR TOWN

BALTO

(If outside corporate limits, write RURAL and give township)

27-10

D. STREET ADDRESS (If rural, give location)

5207 YORK RD.

c. Length of stay in Baltimore

LIFE

Yrs.
Mos.
Days

5. SEX

FEMALE

6. COLOR OR RACE

W

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

MARRIED

8. DATE OF BIRTH

FEB. 12, 1879

9. AGE (in years
last birthday)

71

If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

HOUSEWIFE

10B. KIND OF BUSINESS OR
INDUSTRY

OWN HOME

11. BIRTHPLACE (State or foreign country)

BALTO. MD.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

FRANK SMITH

14. MOTHER'S MAIDEN NAME

AMELIA C. ORT

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

M.V. RUSSELL

SAME

18.

443X

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, ashenia, etc. It means the disease,
injury or complication which caused death.)

(A)

DUE TO

Hypertrophy + Dilatation
of the Heart & Aorta -

1946

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

HYPERTENSIVE CARDIO-
VASCULAR DISEASE.

1941

(C)

INTERVAL BETWEEN
ONSET AND DEATHOTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6-9-41, to 12-2, 1950, that I last saw the
deceased alive on 11-28, 1950, and that death occurred at 4:30 P. M., from the causes and on the date stated above.

23A. SIGNATURE

Anthony F. Carozza

23B. ADDRESS

5217 YORK RD.

23C. DATE SIGNED

12/4/50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

BURIAL

24B. DATE

12-6-1950

24C. NAME OF CEMETERY OR CREMATORY

NEW CATHEDRAL

24D. LOCATION (City, town, or county)

BALTO.

(State)

MD.

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

William Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

H.W. JENKINS & SONS 4905 YORK RD.

VS 150

93D

MEDICAL CERTIFICATION

DR. A. F. CAROZZA

5217 YORK RD.

**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

50-10379
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) DUDLEY WILLIAMS			2. DATE OF DEATH DEC. 3 1950		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institutional residence before admission) A. STATE MD B. COUNTY		
5. FULL NAME OF HOSPITAL OR INSTITUTION 507 CHARING CROSS RD.			C. CITY OR TOWN BALTO.		
c. Length of stay in Baltimore LIFE			D. STREET ADDRESS (If rural, give location) 507 CHARING CROSS RD.		
5. SEX M	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) WIDOWER	8. DATE OF BIRTH JAN. 17, 1877		9. AGE (In years last birthday) 73
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RET. (PHYSICIAN)			10B. KIND OF BUSINESS OR INDUSTRY MEDICAL		11. BIRTHPLACE (State or foreign country) MD.
12. CITIZEN OF WHAT COUNTRY?			13. FATHER'S NAME PHILLIP C. WILLIAMS		
14. MOTHER'S MAIDEN NAME WHITRIDGE			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) YES		
16. SOCIAL SECURITY NO.			17. INFORMANT W.W. WILLIAMS		
18. SP. AMER.			ADDRESS SAME		

18. 4201 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CORONARY THROMBOSIS		INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. ARTERIOSCLEROTIC C.V.D.		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. BRONCHO PNEUMONIA		
19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from Nov. 15, 1950 , to Dec 2 , 1950, that I last saw the deceased alive on Dec. 1 , 1950, and that death occurred at 4 A. M. , from the causes and on the date stated above.		
23A. SIGNATURE J. Pound	23B. ADDRESS 3325 FORBES DRIVE	23C. DATE SIGNED 12/4/50
24A. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24B. DATE 12-4-1950	24C. NAME OF CEMETERY OR CREMATORY GREENMOUNT
24D. LOCATION (City, town, or county) BALTO.	24E. LOCATION (City, town, or county) (State) MD.	
DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE H. W. JENKINS & SONS	25. FUNERAL DIRECTOR H. W. JENKINS & SONS
ADDRESS 4905 YORK RD.		

DEC 5 1950

07580

93D

MEDICAL CERTIFICATION

DR. J. C. POUND

3325 FREDERICK AVE.

5-322

50-10380

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10380

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

BRIDY STOKES

2. DATE
OF
DEATH

DEC 3, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland REC. Room

B. FULL NAME OF
HOSPITAL OR
INSTITUTION

THE JOHNS HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence
before admission)

A. STATE

MARYLAND

B. COUNTY

C. CITY OR TOWN

BALTIMORE

(If outside corporate limits, write RURAL and give
township)

D. STREET ADDRESS (If rural, give location)

806 Mc Donogh St.

c. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

FEMALE

6. COLOR OR RACE

COLORED

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

SINGLE

8. DATE OF BIRTH

2-6-06

9. AGE (in years
last birthday)

44

If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Ma

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

ALDEN ALLEN

14. MOTHER'S MAIDEN NAME

ELLE SMITH

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

THE JOHNS HOPKINS HOSPITAL

18. 153X

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) Cerebro-Vascular accident

36 h.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) Antemortem

DUE TO

(C) Inoperable Ca Signified.

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

11-29-50

19B. MAJOR FINDINGS OF OPERATION

Destructive tumor of sigmoidic intestine

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT WAS UNDER-
LYING OR CONTRIBUTING
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE
WORK AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11-29 1950 to 12-3 1950, that I last saw the
deceased alive on 12-3 1950, and that death occurred at 7:20 p. m., from the causes and on the date stated above.

23A. SIGNATURE

Wm. J. Hennick

M. D.

23B. ADDRESS

THE JOHNS HOPKINS HOSPITAL

23C. DATE SIGNED

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

Dec. 7 1950

24C. NAME OF CEMETERY OR CREMATORY

Mt Calvary Cem

24D. LOCATION (City, town, or county)

QA County, Va.

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

Mrs. G. R. Elliott & Daughter

1129 N. Caroline St. 46E

74-10884

74-10884

County of ...

State of ...

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C-200

50-10381

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50-10381
Registered No.

BIRTH NO. 50-27028

1. NAME OF DECEASED (Type or Print) <i>Joseph Cook</i>		2. DATE OF DEATH <i>Dec 2, 1950</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>md</i> B. COUNTY <i>16-06</i>	
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>Lutheran Hosp of Md</i>		C. CITY OR TOWN <i>Balto 16</i> (If outside corporate limits, write RURAL and give township)	
c. Length of stay in Baltimore <i>2</i> <small>Yes. Mos. Days</small>		D. STREET ADDRESS (If rural, give location) <i>2752 W Lafayette Ave</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>child</i>	8. DATE OF BIRTH <i>11/30/50</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <i>2</i> <small>If Under 1 Year: Months: Days: Hours: Min.</small>
11. BIRTHPLACE (State or foreign country) <i>Lutheran Hosp of Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>—</i>	
13. FATHER'S NAME <i>Matthew Cook</i>		14. MOTHER'S MAIDEN NAME <i>Lucy Mary Speranzella</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, oo or unknowns) <i>—</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>—</i>	
17. INFORMANT <i>mother</i>		ADDRESS <i>Same</i>	

18. *7700*
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

(A) *Erythroblastosis fetalis*
DUE TO*2 days*

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) *Rh incompatibility*
DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION *2* 19B. MAJOR FINDINGS OF OPERATION20. AUTOPSY?
YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED
WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *11/30*, 1950, to *12/2*, 1950, that I last saw the deceased alive on *12/2*, 1950, and that death occurred at *6:32* pm., from the causes and on the date stated above.23A. SIGNATURE *Marian S. Daly*23B. ADDRESS *Lutheran Hosp. of Md*23C. DATE SIGNED *12/4/50*24A. BURIAL, CREMATION, REMOVAL (Specify) *Burial*24B. DATE *Dec. 5, 1950*24C. NAME OF CEMETERY OR CREMATORY *New Cathedral*24D. LOCATION (City, town, or county) *Baltimore, Md.*

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE *John T. Stansbury*

25. FUNERAL DIRECTOR

ADDRESS *Edmondson Arc.*

DEC 4 1950

161c

100-10081

RECEIVED
COMMUNICATIONS SECTION
JAN 10 1964

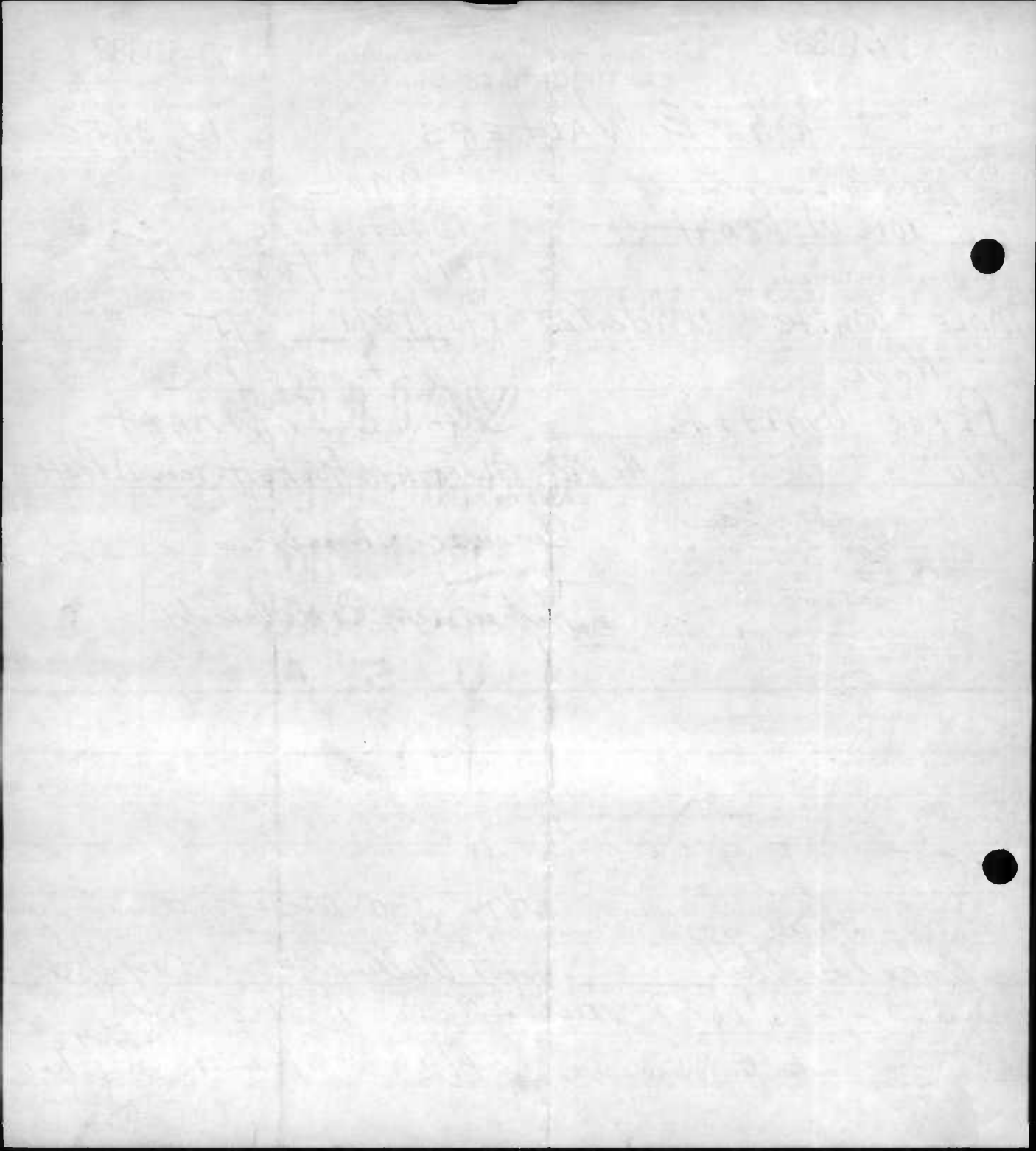
100-10081

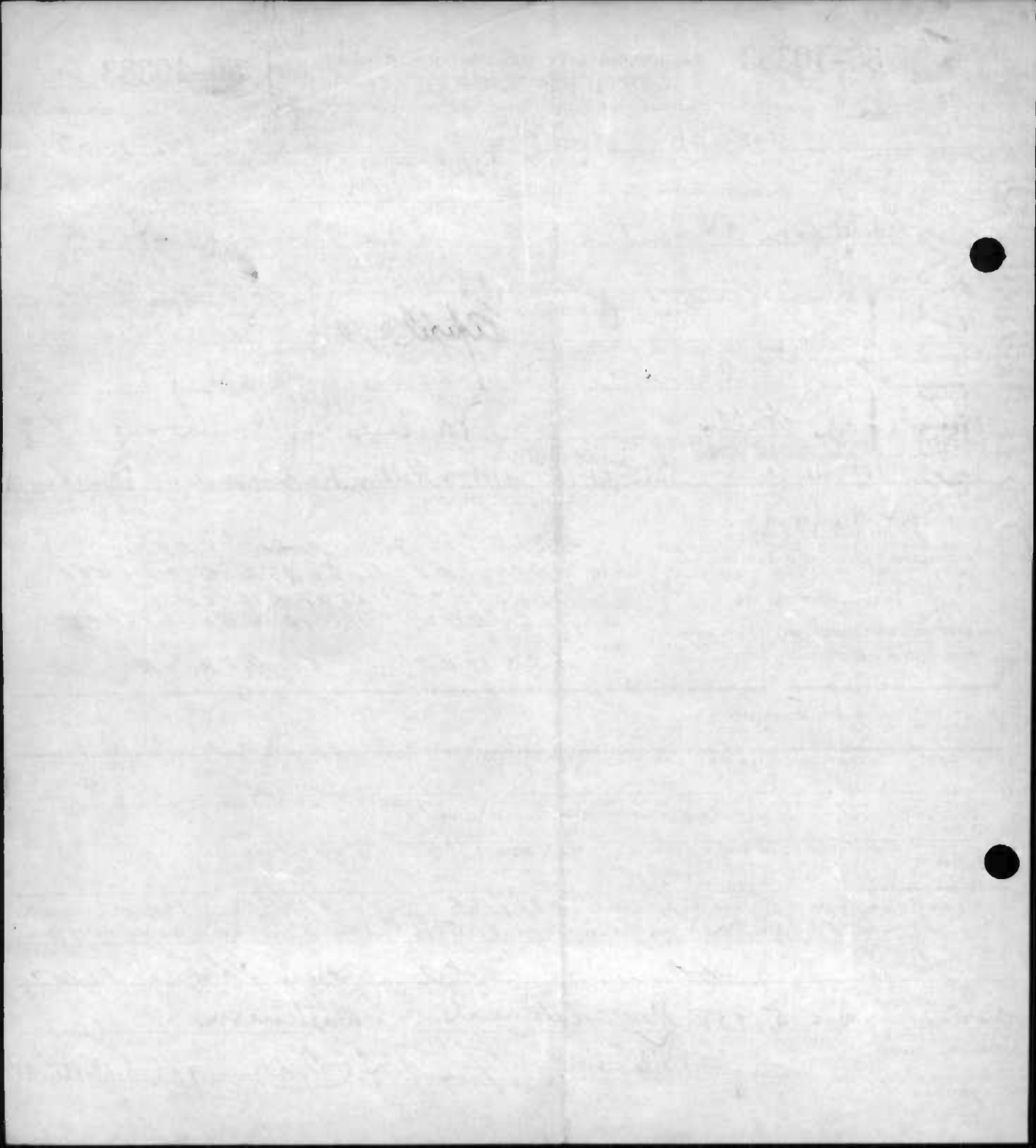


W-4 3610382

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50-10382
Registered No.

BIRTH NO.		1. NAME OF DECEASED (Type or Print) JOHNE E. WALTERS		2. DATE OF DEATH 12/3/50	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD B. COUNTY			
B. FULL NAME OF HOSPITAL OR INSTITUTION 1016 W. PRATT ST		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE 18-03			
c. Length of stay in Baltimore		D. STREET ADDRESS (If rural, give location) 1016 W. PRATT ST			
5. SEX MALE	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED	8. DATE OF BIRTH 5/5/1875	9. AGE (In years last birth day) 75	10. Under 1 Year Months: Days 11. Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during years of working life, even if retired) NONE		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) BALTIMORE MD	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME PETER WALTERS		14. MOTHER'S MAIDEN NAME SARAH E. LAINHART	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT ADDRESS ALVERTA M. PUCKETT 1016 W. PRATT ST	
18. 420.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Cerebral Thrombosis		CAUSE OF DEATH (A) DUE TO Hypertensive Cordiopathy		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO			
(C) DUE TO					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Nov 14 , 19 50 , to Dec 2 , 19 50 , that I last saw the deceased alive on Dec 2 , 19 50 , and that death occurred at 39 m., from the causes and on the date stated above.					
23A. SIGNATURE Robert E. Welch		23B. ADDRESS 257 Wilkins Ave		23C. DATE SIGNED 12/8/50	
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE 12/6/50		24C. NAME OF CEMETERY OR CREMATORY Baltimore Cem.	
24D. LOCATION (City, town, or county) (State) BALTO MD		24E. FUNERAL DIRECTOR Walter C. M. Walters		24F. ADDRESS 1016 W. PRATT ST	
DATE RECEIVED BY LOCAL REGISTRAR DEC 4 - 1950		REGISTRAR'S SIGNATURE Walter C. M. Walters		25. FUNERAL DIRECTOR Walter C. M. Walters	





K-450-10384

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50-10384

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Robert L. Kelly

2. DATE
OF
DEATH

12-3-50

3. PLACE OF DEATH:

a. Baltimore City, Maryland

b. FULL NAME OF
HOSPITAL OR
INSTITUTION

Herring Run Park

Yrs.
Mos.
Days

c. Length of stay in Baltimore

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

a. STATE

b. COUNTY

Maryland

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore 2-7-01

d. STREET ADDRESS (If rural, give location)

3220 Lyndale Ave.

5. SEX

male

6. COLOR OR RACE

white

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

married

8. DATE OF BIRTH

Aug 19-1961

9. AGE (In years
last birthday)

49

10. Under 1 Year
Months Days11. Under 24 Hours
Hours Min.10a. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Shannon News

10b. KIND OF BUSINESS OR
INDUSTRY

Metro St. C.

11. BIRTHPLACE (State or foreign country)

Wichita, Kansas

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Robert L. Kelly

14. MOTHER'S MAIDEN NAME

Susan Chandler

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs Dorothy M. Kelly

Same

18. E976 X 1

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)(A) Gun Shot Wound of Chest
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) DUE TO
(C)II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21a. EXTERNAL CAUSE WAS
UNDERLYING ☒ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.21b. PLACE OF INJURY (a. g., in or
about home, farm, factory, street, office bldg., etc.)

Park

21c. WHERE DID (If in Baltimore City, give exact location)

Herring Run Park, 100' off Chesterfield

21d. TIME (Month) (Day) (Year) (Hour)

OF INJURY

Dec. 3, 1950

21e. INJURY OCCURRED

A. m.

WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21f. HOW DID INJURY OCCUR?

Firearms

22. I certify that I took charge of the remains described above, held an Inspection & Inquiry thereon and from
Autopsy, Inspection or Inquiry
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,
and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐.

23a. SIGNATURE

William W. Williams

23b. CHIEF MEDICAL EXAMINER.....☐ASSISTANT MEDICAL EXAMINER.....☒MEDICAL INVESTIGATOR.....☐

23c. DATE SIGNED

12-3-50

24a. BURIAL, CREMA-
TION, REMOVAL (Specify)

24b. DATE

24c. NAME OF CEMETERY OR CREMATORY

24d. LOCATION (City, town, or county) (State)

DATE RECEIVED BY
LOCAL REGISTRAR

DEC 4 - 1950

REGISTRAR'S SIGNATURE

William W. Williams, M.D.

25. FUNERAL DIRECTOR

L. J. Luck

ADDRESS

5305 Nayford Rd

VS 151

N-8754

4903D

164c

MEDICAL CERTIFICATION

M-610
50-10385BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50-10385
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <i>Margaret Murphy</i>		2. DATE OF DEATH <i>Dec. 2-1950</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY	
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <i>3718 Woodridge Ave.</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore 16-08</i>	
c. Length of stay in Baltimore Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) <i>3718 Woodridge Road</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Widowed</i>	8. DATE OF BIRTH <i>Sept. 15-1847</i>
9. AGE (In years, last birthday) <i>103</i>		10. Under 1 Year Months: Days 11. Under 24 Hours Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>at home</i>		10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Brooklyn, N.Y.</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>John White</i>		14. MOTHER'S MAIDEN NAME <i>2.</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>James Murphy</i>		ADDRESS <i>3718 Woodridge</i>	
18. <i>332X</i> I CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) <i>Cerebral Thrombosis</i> DUE TO ANTECEDENT CAUSES (B) <i>Generalized Arteriosclerosis</i> DUE TO (C) <i>II</i> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION <i>None</i>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>9/24/40</i> , 19__, to <i>12/2/50</i> , 19__, that I last saw the deceased alive on <i>12/2/50</i> , 19__, and that death occurred at <i>1:30 p.m.</i> , from the causes and on the date stated above.			
23A. SIGNATURE <i>Seagriff Rump</i>		23B. ADDRESS <i>3030 Edmondson Avenue</i>	
23C. DATE SIGNED <i>12/4/50</i>			
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>12/5/50</i>	
24C. NAME OF CEMETERY OR CREMATORY <i>New Cathedral</i>		24D. LOCATION (City, town, or county) (State) <i>Balto Md.</i>	
DATE RECEIVED BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE <i>Huntington Williams</i>	
25. FUNERAL DIRECTOR <i>J. Luck</i>		ADDRESS <i>5305 Harford Road</i>	

DEC 4-1950

8312

Dr. Kipp
3030 Colmanston

30-10306

1750

NAC-DAL-EN-02-0000

NOV 19 1964

DALE W. GLENN

1000 11-19-64

1000 11-19-64

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1000 11-19-64

436

50-10387

BALTIMORE CITY HEALTH DEPARTMENT

50-10387

CERTIFICATE OF DEATH

Registered No.

BIRTH NO. 50-26043

1. NAME OF DECEASED
(Type or Print)John Edward
(Baby Boy) Alder

2. DATE

OF
DEATH

12-3-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution; residence

A. STATE

B. COUNTY

before admission)

B. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR
INSTITUTION

University

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

5203 Beau forte Ave

c. Length of stay in Baltimore

Yrs.
Mos.
Days

6

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

11-28-50

9. AGE (In years

last birthday)

If Under 1 Year

Months; Days

If Under 24 Hours

Hours; Min.

6

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Paul E. Alder

14. MOTHER'S MAIDEN NAME

Martha S. Crowther

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL

SECURITY NO.

17. INFORMANT

ADDRESS

Paul E. Alder 5203 Beau forte Ave

18. 770.1 I

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

Kernicterus

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

Erythroblastosis Fetalis

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11-28, 1950, to 12-3, 1950, that I last saw the deceased alive on 12-2, 1950, and that death occurred at 2:15 A.M., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

12-3-50

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

DEC 4 - 1950

Loring Byers

5005 Pk. Heights Ave

10-10-68
UNITED STATES OF AMERICA
DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D.C. 20535

10-10-68

300

50-10388

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50-10388
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print) HARRISON RAE WHITE

2. DATE OF DEATH Nov. 30, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE New York B. COUNTY V-29B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR US Marine Hospital
INSTITUTION Woman Pk. Drive & 31st St.C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Buffaloc. Length of stay in Baltimore 37 days
Yrs. Mos. DaysD. STREET ADDRESS (If rural, give location)
201 Ellicott Street

5. SEX M 6. COLOR OR RACE W 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married

8. DATE OF BIRTH 8/30/11 9. AGE (In years last birthday) 39 10 Under 1 Year Months Days 11 Under 24 Hours Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Oiler10B. KIND OF BUSINESS OR INDUSTRY
Seafarer11. BIRTHPLACE (State or foreign country)
NY12. CITIZEN OF WHAT COUNTRY?
USA13. FATHER'S NAME
Harrison S. White14. MOTHER'S MAIDEN NAME
Helen Rae

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) ? (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.
070-09-489417. INFORMANT ADDRESS
Records- US Marine Hospital, Balto, Md.18. 162X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

(A) Carcinoma right lung (apex)
DUE TO with bilateral adrenal metastases

6 mos +

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION 19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?
YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED
WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct. 24, 1950, to Nov. 30, 1950, that I last saw the deceased alive on Nov. 30, 1950, and that death occurred at 11:25A m., from the causes and on the date stated above.

23A. SIGNATURE
John L. Wilson, Medical Director23B. ADDRESS
US Marine Hospital, Balto, Md.23C. DATE SIGNED
12/1/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

DEC 4 - 1950

66255

403-8-25th St. 47D

100-10000

CERTIFICATE OF DEATH

100-10000

1. Name of deceased		2. Sex		3. Race		4. Date of birth		5. Place of birth		6. Date of death		7. Place of death		8. Cause of death		9. Manner of death		10. Signature of physician		11. Signature of registrar		12. Signature of informant	

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50-10389

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10389

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Mrs. Marie Hughes		2. DATE OF DEATH Dec. 2, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION St. Joseph's Hospital		C. CITY OR TOWN (If outside corporate limits, write LOCAL and give township) Baltimore	
c. Length of stay in Baltimore		D. STREET ADDRESS (If rural, give location) 408 N. Robinson Street	
5. SEX Fe.	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Oct 3, 1894
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Wife.		9. AGE (In years last birthday) 56	
10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
13. FATHER'S NAME FRANK KUS		12. CITIZEN OF WHAT COUNTRY?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO. 215-01-8729	
17. INFORMATION		ADDRESS FRANK LIPA 132 ELINORA AVE	

18. **420.1 I**
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A)

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>12/1/</u> , 19 <u>50</u> , to <u>12/2/</u> , 19 <u>50</u> that I last saw the deceased alive on <u>12/2/</u> , 19 <u>50</u> , and that death occurred at <u>8:45AM.</u> , from the causes and on the date stated above.					
23A. SIGNATURE Maddena Swinski		23B. ADDRESS 1400 N. Caroline Street		23C. DATE SIGNED 12/2/50	
24A. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 12-5-50		24C. NAME OF CEMETERY OR CREMATORY HOLY REDEEMER	
24D. LOCATION (City, town, or county) BALTIMORE MD		24E. DATE RECEIVED BY LOCAL REGISTRAR		24F. REGISTRAR'S SIGNATURE Wilmington Williams, Jr.	
24G. FUNERAL DIRECTOR FRANK CVACH & SON		24H. ADDRESS 900 N. CHESTER ST		24I. DATE RECEIVED BY LOCAL REGISTRAR	

C 4-1950

94a

50-10389

CERTIFICATE OF DEATH

50-10389

1. Name of deceased		2. Sex		3. Race		4. Date of birth		5. Place of birth		6. Date of death		7. Place of death		8. Cause of death		9. Manner of death		10. Signature of physician		11. Signature of registrar		12. Signature of informant	

340
50-10390BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50-10390

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)*Katherine Hartley*2. DATE
OF
DEATH*12-2-50*

3. PLACE OF DEATH:

A. Baltimore City, Maryland

*Baltimore*B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR INSTITUTION*411 Pittman Place*4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE*Md.*

B. COUNTY

C. CITY OR TOWN

Balto - Md.

D. STREET ADDRESS (If rural, give location)

1506 E. Lafayette Ave.

c. Length of stay in Baltimore

Life

5. SEX

F.

6. COLOR OR RACE

*W.*7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)*Widowed*

8. DATE OF BIRTH

*11-11-06*AGE (in years
last birthday)*44*H Under 1 Year
Months: DaysH Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)*Housewife*10B. KIND OF BUSINESS OR
INDUSTRY*Home*

11. BIRTHPLACE (State or foreign country)

*Baltimore*12. CITIZEN OF
WHAT COUNTRY?*U.S.A.*

13. FATHER'S NAME

Rudolph Schreiber

14. MOTHER'S MAIDEN NAME

*?*15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

*Wm. Hartley 1506 E. Lafayette Ave.*18. *154X*

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)(A) *Generalized carcinomatosis*

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

DUE TO

(C)

(B) *Carcinoma of rectum*OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

27 May 50

19B. MAJOR FINDINGS OF OPERATION

Carcinoma of rectum

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDER-
LYING OR CONTRIBUTING
CAUSE OF DEATH21B. PLACE OF INJURY (e.g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

m. WHILE AT ☐ NOT WHILE
WORK AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *9 October, 1950* to *2 December, 1950* that I last saw the
deceased alive on *30 Nov*, 1950 and that death occurred at *12 A.M.*, from the causes and on the date stated above.

23A. SIGNATURE

John H. Barnaby

23B. ADDRESS

M. D. 1531 E North Ave

23C. DATE SIGNED

*4 Dec 50*24A. BURIAL, CREMA-
TION, REMOVAL (Specify)*Burial*

24B. DATE

12-5-50

24C. NAME OF CEMETERY OR CREMATORY

National

24D. LOCATION (City, town, or county)

Balto - Md

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Wm. Williams, Jr.

25. FUNERAL DIRECTOR

ADDRESS

*DEC 5 - 1950**Felly & Zailer - 403 N. Holler St.*

Dr. Barnaby -
1531 E. North Ave
Mun - 8426.

622
50-10391BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50-10391

1. NAME OF DECEASED (Type or Print) <i>Lena Marcus</i>		2. DATE OF DEATH <i>12/4/50</i>	
3. PLACE OF DEATH: a. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY	
b. FULL NAME OF HOSPITAL OR INSTITUTION <i>women's Hosp.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore 15-58</i>	
c. Length of stay in Baltimore <i>60</i> Yrs. <i>60</i> Mos. <i>60</i> Days		d. STREET ADDRESS (If rural, give location) <i>3603 Springdale Ave.</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>white</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>widow</i>	8. DATE OF BIRTH <i>9/15/1873</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>N.W.</i>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <i>77</i>
11. BIRTHPLACE (State or foreign country) <i>Russia</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Ruben Lipsitz</i>		14. MOTHER'S MAIDEN NAME <i>unknown</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Archie Kofkeimer</i>		ADDRESS <i>- same</i>	
18. <i>470.0</i> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH <i>Pulmonary edema</i> (A) DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) <i>Arteriosclerotic Heart Disease</i> DUE TO (C) <i>Nodular Pancreatitis</i> <i>Portal Cirrhosis</i> <i>Diabetes Mellitus</i> II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION <i>2</i>		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		21b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21d. TIME (Month) (Day) (Year) (Hour) INJURY	
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>12/1</i> 1950, to <i>12/4</i> , 1950, that I last saw the deceased alive on <i>12/4</i> , 1950, and that death occurred at <i>2:00</i> p.m., from the causes and on the date stated above.			
23a. SIGNATURE <i>Mark E. Hall, Jr.</i>		23b. ADDRESS <i>women's Hosp</i>	
23c. DATE SIGNED <i>12/4/50</i>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24b. DATE <i>12-5-50</i>	
24c. NAME OF CEMETERY OR CREMATORY <i>Beth Tabor</i>		24d. LOCATION (city, town, or county) (State) <i>Baltimore Md</i>	
25. FUNERAL DIRECTOR <i>Jack Lewis Inc</i>		ADDRESS <i>2100 Eutaw Pl</i>	
DATE RECEIVED BY LOCAL REGISTRAR <i>DEC 5 - 1950</i>		REGISTRAR'S SIGNATURE <i>William M. Williams</i>	

1001-10

1001-10

[Faint, illegible handwriting throughout the page, possibly bleed-through from the reverse side.]

425
50-10392

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50-10392

1. NAME OF DECEASED (Type or Print) <i>SADIE FLEISHMAN</i>			2. DATE OF DEATH <i>12/4/50</i>		
3. PLACE OF DEATH: a. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) a. STATE <i>Maryland</i> b. COUNTY		
b. FULL NAME OF HOSPITAL OR INSTITUTION <i>Women's Hospital</i>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore</i>		
c. Length of stay in Baltimore			d. STREET ADDRESS (If rural, give location) <i>826 Brooks Lane</i>		
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Widowed</i>	8. DATE OF BIRTH <i>Oct 14 1884</i>		9. AGE (in years last birthday) <i>66</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>-</i>	11. BIRTHPLACE (State or foreign country) <i>Pennsylvania</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13. FATHER'S NAME <i>Norman Wosman</i>			14. MOTHER'S MAIDEN NAME <i>Annie Aaron</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>No</i>		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS <i>Florence Fleishman - Home</i>		

18. <i>260X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH
(A) DUE TO		<i>Infection of Myocardium</i>		
ANTECEDENT CAUSES		(B) <i>Gen'l Atherosclerosis</i>		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(C) <i>Diabetes Mellitus</i> <i>Pulmonary Infection</i>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				

19a. DATE OF OPERATION <i>0</i>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		21b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>11/22</i> 19 <i>50</i> , to <i>12/4</i> 19 <i>50</i> , that I last saw the deceased alive on <i>12/3</i> 19 <i>50</i> , and that death occurred at <i>9:21</i> a. m., from the causes and on the date stated above.					
23a. SIGNATURE <i>Mark E. Hall, Jr.</i>		23b. ADDRESS <i>Women's Hosp.</i>		23c. DATE SIGNED <i>12/4/50</i>	
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE <i>12-6-50</i>		24c. NAME OF CEMETERY OR CREMATORY <i>Adas Israel Washington D.C.</i>	
24d. LOCATION (City, town, or county) (State) <i>D.C.</i>		25. FUNERAL DIRECTOR <i>Jack Lewis</i>		25. ADDRESS <i>2100 Eutan Pl</i>	
DATE RECEIVED BY LOCAL REGISTRAR <i>DEC 5 - 1950</i>		REGISTRAR'S SIGNATURE <i>Wilmington Williams, M.D.</i>			

SLASH-1

STANDARD

SLASH-1

STANDARD

10

260
50-10393BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50-10393

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

BERNARD G. BAKER

2. DATE
OF
DEATH

Nov. 26, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION

Johns Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore

D. STREET ADDRESS (If rural, give location)

838 McAleer Court

C. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

U

8. DATE OF BIRTH

U

9. AGE (In years
last birthday)

45

If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR
INDUSTRY

K

11. BIRTHPLACE (State or foreign country)

K

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

N

14. MOTHER'S MAIDEN NAME

O

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

N

17. INFORMANT

N

ADDRESS

18. 002 X I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A)

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Inspection & Aug. thereon and from
Autopsy, Inspection or Inquiry
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,
and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

23B. CHIEF MEDICAL EXAMINER.....☐
ASSISTANT MEDICAL EXAMINER.....☐
MEDICAL INVESTIGATOR.....☐

23C. DATE SIGNED

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

UNIVERSITY MEDICAL SCHOOL DEC 1 1950

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

DEC 5 - 1950

Commissioner of Health

100-100

UNITED STATES DEPARTMENT OF JUSTICE

RECORDS SECTION

(60)

[Faint, mostly illegible text covering the majority of the page, likely bleed-through from the reverse side. The text appears to be organized into sections or paragraphs, but the specific words are difficult to discern.]

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHRegistered No. 50-10394

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

JOHN

MOODY

2. DATE
OF DEATH November 3, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution: residence
A. STATE Maryland B. COUNTY _____ before admission)B. FULL NAME OF (If not in hospital or institution, give street address or
HOSPITAL OR location)
INSTITUTION

Johns Hopkins Hospital

C. CITY OR TOWN (If outside corporate limits, write full name and give
Baltimore township)

D. STREET ADDRESS (If rural, give location)

1106 E. Pratt Street

C. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

Male

6. COLOR OR RACE

Colored

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

U

8. DATE OF BIRTH

U

9. AGE (In years
last birthday)

65?

If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR
INDUSTRY

K

11. BIRTHPLACE (State or foreign country)

K

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

N

14. MOTHER'S MAIDEN NAME

O

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

N

17. INFORMANT

N

ADDRESS

CAUSE OF DEATH

18. 4221 IDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, ashenia, etc. It means the disease,
injury or complication which caused death.)

Arteriosclerotic cardiovascular disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

DUE TO

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.INTERVAL BETWEEN
ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY21E. INJURY OCCURRED
WHILE AT ☐ NOT WHILE ☐
m. WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Insp. & Inquiry thereon and from
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,
and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

23B. CHIEF MEDICAL EXAMINER.....
ASSISTANT MEDICAL EXAMINER.....
M.D. MEDICAL INVESTIGATOR.....

23C. DATE SIGNED

11-28-50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

UNIVERSITY MEDICAL SCHOOL DEC 1 - 1950

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

DEC 5 - 1950

V S 151

VVV99

93D ✓

MEDICAL CERTIFICATION

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registration No.

DATE

TIME

NAME

AGE

SEX

RACE

EDUCATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

DATE OF BURIAL

PLACE OF BURIAL

CAUSE OF DEATH

MANNER OF DEATH

DATE OF BURIAL

PLACE OF BURIAL

DATE OF BURIAL

PLACE OF BURIAL

DATE OF BURIAL

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DATE OF BURIAL

PLACE OF BURIAL

DATE OF BURIAL

PLACE OF BURIAL

260
50-10395
N.D.-136649BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10395

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Thomas Keiger			2. DATE OF DEATH Nov. 22, 1950		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY		
B. FULL NAME OF (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Avenue			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore		
c. Length of stay in Baltimore 1 year ? Yrs. Mos. Days			D. STREET ADDRESS (If rural, give location) 731 W. Lexington Street		
5. SEX M	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH Dec. 29, 1875	9. AGE (In years last birthday) 74	10. Under 1 Year Months: Days 11. Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country) N.C.		
10B. KIND OF BUSINESS OR INDUSTRY			12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME Edwin			14. MOTHER'S MAIDEN NAME Elizabeth Moser		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
17. INFORMANT'S ADDRESS Baltimore City Hospitals Records: 4940 Eastern Avenue					

18. 490X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Acute pneumonia DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Coronary Occlusion Hypertensive Cardio- Vascular Disease	INTERVAL BETWEEN ONSET AND DEATH 3 Days 3 to 4 Days Unknown
---	---

19A. DATE OF OPERATION 0	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **7-28**, 19**49**, to **11-22-**, 19**50**, that I last saw the deceased alive on **11-22-**, 19**50**, and that death occurred at **12.25pm**, from the causes and on the date stated above.

23A. SIGNATURE <i>W. H. Hogen</i>	23B. ADDRESS M. D. 4940 Eastern Avenue	23C. DATE SIGNED 11-27-50
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24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY UNIVERSITY MEDICAL SCHOOL DEC 1 - 1950	24D. LOCATION (City, town, or county) (State)
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DATE RECEIVED BY LOCAL REGISTRAR DEC 5 - 1950	REGISTRAR'S SIGNATURE <i>W. H. Hogen</i>	25. FUNERAL DIRECTOR Commissioner of Health	ADDRESS
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CHINESE

623
50-10396BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50-10396

BIRTH NO.

50-25792

1. NAME OF DECEASED
(Type or Print)

Baby Boy Preston

2. DATE
OF
DEATH

11/27/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION

Lutheran Hosp of Md

C. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)4. USUAL RESIDENCE (Where deceased lived. If institution: residence
A. STATE B. COUNTY before admission)

Md

C. CITY OR TOWN (If outside corporate limits, write full name and give township)

Balto 26

25-05

D. STREET ADDRESS (If rural, give location)

4100 Curtis Ave

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

11/26/50

9. AGE (In years
last birthday)

10 Under 1 Year

Months: Days

10 23

10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Balto Md

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Lawrence William Preston

14. MOTHER'S MAIDEN NAME

Fern Estelle Frantum

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

mother

18. 762.0 I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A)

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11/26, 1950 to 11/27, 1950, that I last saw the
deceased alive on 11/27, 1950, and that death occurred at 12:58 A. M., from the causes and on the date stated above.

23A. SIGNATURE

Norman L. ...

M. D.

23B. ADDRESS

Lutheran Hosp of Md

23C. DATE SIGNED

11/29/50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

Commissioner of Health

620

50-10397

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50-10397

BIRTH NO. 50-27349

1. NAME OF DECEASED (Type or Print) <i>Baby Bay Price</i>			2. DATE OF DEATH <i>Nov 28, 1950</i>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Ind</i> B. COUNTY <i>Anne Arundel</i>		
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>Lutheran Hosp of Md</i>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Balto Pasadena</i>		
C. Length of stay in Baltimore <i>25</i> Yrs. Mos. Days			D. STREET ADDRESS (If rural, give location) <i>Mt Pleasant Beach 5200</i>		
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH <i>Nov 28, 1950</i>	9. AGE (In years last birthday)	If Under 1 Year Months: Days If Under 24 Hours Hours Min. <i>2 42</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>Balto Md</i>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <i>Richard Austin Price</i>			14. MOTHER'S MAIDEN NAME <i>Doris Evelyn Willey</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT <i>Mother</i>		ADDRESS <i>Same</i>

1B. <i>762.5</i> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	CAUSE OF DEATH (A) <i>Atelectasis, bilateral</i> DUE TO	INTERVAL BETWEEN ONSET AND DEATH <i>2.42 hrs</i>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B) <i>Prematurity</i> DUE TO	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	(C)	

19A. DATE OF OPERATION <i>2</i>	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *11/28* 19*50*, to *11/28*, 19*50* that I last saw the deceased alive on *11/28*, 19*50*, and that death occurred at *536* A. m., from the causes and on the date stated above.

23A. SIGNATURE <i>Daniel Silverstein</i>	23B. ADDRESS <i>Lutheran Hosp of Md.</i>	23C. DATE SIGNED <i>11/29/50</i>
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24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY <i>JOHN HOPKINS MEDICAL SCHOOL</i>	24D. LOCATION (City, town, or county) (State) <i>DEC 4 - 1950</i>
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DATE RECEIVED BY LOCAL REGISTRAR <i>DEC 5 - 1950</i>	REGISTRAR'S SIGNATURE <i>Huntington Williams, M.D.</i>	25. FUNERAL DIRECTOR <i>Commissioner of Health</i>	ADDRESS
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VERO-10

VERO-10

VERO-10



625
50/10398
50/10398
BIRTH NO.BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50/10398
Registered No. 50/10398

1. NAME OF DECEASED (Type or Print) John D. Harrison			2. DATE OF DEATH Dec. 3/1950		
3. PLACE OF DEATH: A. Baltimore City, Maryland 2507 Garrison Blvd.			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. C. CITY OR TOWN Balto. D. STREET ADDRESS (If rural, give location) 2507 Garrison Blvd.		
B. FULL NAME OF HOSPITAL OR INSTITUTION			9. AGE (In years last birthday) 85		
c. Length of stay in Baltimore			8. DATE OF BIRTH Oct. 5, 1865		
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	12. CITIZEN OF WHAT COUNTRY? U.S.A.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Produce Owner		10B. KIND OF BUSINESS OR INDUSTRY Produce Bus.	11. BIRTHPLACE (State or foreign country) Calvert Co., Md.		
13. FATHER'S NAME Clement Harrison		14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknowns) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Jennie E. Harrison 2507 Garrison	
		ADDRESS Blvd.			

18. CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) Pneumonia DUE TO		5 days
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) Arterio sclerosis DUE TO		20yrs.
(C)		

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from Nov. 25/1950, to Dec. 2/1950, that I last saw the deceased alive on Dec. 2/1950, and that death occurred at m., from the causes and on the date stated above.

23A. SIGNATURE Catherine Davis	23B. ADDRESS M. D. 800 33rd. St.	23C. DATE SIGNED Dec. 4/50
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24A. BURIAL, CREMATION, REMOVAL (Specify) Burial	24B. DATE Dec. 5/50	24C. NAME OF CEMETERY OR CREMATORY Loudon Pk.	24D. LOCATION (City, town, or county) (State) Baltimore
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DATE RECEIVED BY LOCAL REGISTRAR Dec. 5/50	REGISTRAR'S SIGNATURE Huntington Williams MD	25. FUNERAL DIRECTOR Loring Byers	ADDRESS 500 Pk. Hghts. Ave.
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5



650

CERTIFICATE CORRECTED 12-15-50

50-10399

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50-10399
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)ANNIE
*Birdie Irwin*2. DATE
OF
DEATH

Dec. 4, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland *4511 Homer Ave*

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION

C. CITY OR TOWN

(If outside corporate limits, state RURAL and give township)

D. STREET ADDRESS (If rural, give location)

C. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years
last birthday)10 Under 1 Year
Months: Days11 Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTH PLACE (State or foreign country)

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

18. *443 X*

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A)

*Cardiac Decompensation**36 hrs*

DUE TO

*Shock from vomiting**36 hrs*

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

*Paraplegia**4 1/2 hrs.*

DUE TO

*Hypertension**Unknown*

(C)

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m.

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐22. I hereby certify that I attended the deceased from *July*, 1950, to *Dec 4th*, 1950, that I last saw the
deceased alive on *12-4-*, 1950, and that death occurred at *5:30* p. m., from the causes and on the date stated above.

23A. SIGNATURE

G. B. Euser

M. O.

23B. ADDRESS

7201 York Rd

23C. DATE SIGNED

*12-4-1950*24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

*DEC 5 - 1950**Washington Williams, M.D.**Loring Eyer 5005 E. Heights*

STATE OF TEXAS

IN SENATE,
January 11, 1901.

REPORT
OF THE
COMMISSIONER OF THE
LAND OFFICE,
FOR THE YEAR
1900.

ALBUQUERQUE, N. M.,
JANUARY 11, 1901.

THE SENATE,

TO WHICH
THE REPORT IS
RESPECTFULLY
SUBMITTED.

BY
J. M. HARRIS,
COMMISSIONER.

BALTIMORE CITY HEALTH DEPARTMENT

50-10400

CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED
(Type or Print)

Johnson "Baby Boy"

2. DATE
OF
DEATH

DEC 1, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland HLH-PN

4. USUAL RESIDENCE (Where deceased lived. If institution: residence
A. STATE B. COUNTY before admission)

MARYLAND

B. FULL NAME OF
HOSPITAL OR
INSTITUTION (If not in hospital or institution, give street address or
location)

JOHNS HOPKINS HOSPITAL

C. CITY OR TOWN (If outside corporate limits, write RURAL and give
township)

BALTIMORE

c. Length of stay in Baltimore

Yrs.
Mos.
Days

D. STREET ADDRESS (If rural, give location)

2902

Southland

5. SEX

MALE

6. COLOR OR RACE

COLORED

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

SINGLE

8. DATE OF BIRTH

11-28-50

9. AGE (In years
last birthday)10. Under 1 Year
Months: Days11. Under 24 Hours
Hours: Min.

3

10A. USUAL OCCUPATION (Give kind of
work done during most of worklog life, even if retired)10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Ulysses Johnson

14. MOTHER'S MAIDEN NAME

?

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or ookeowo) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT, JOHNS HOPKINS HOSPITAL ADDRESS

18. 771.5

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A)

DUE TO

Hemorrhagic disease of
newborn

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

Prematurity

(C)

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m.

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐22. I hereby certify that I attended the deceased from 11-28, 1950, to 12-1, 1950, that I last saw the
deceased alive on 12-1, 1950, and that death occurred at 2 a.m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

JOHNS HOPKINS HOSPITAL

23C. DATE SIGNED

12-1-50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

DEC 5 - 1950

Horton Williams, M.D.

10-1-100

RECEIVED

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230
REA-139898BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10401

Registered No.

BIRTH NO. 50-10401

1. NAME OF DECEASED
(Type or Print)

Charles West

2. DATE
OF
DEATH

Nov. 25, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION

Baltimore City Hospitals

4940 Eastern Avenue

Yrs.
Mos.
Days

C. Length of stay in Baltimore

Life

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Single

10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

UNKNOWN

10B. KIND OF BUSINESS OR
INDUSTRY

13. FATHER'S NAME

Thomas West

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.4. USUAL RESIDENCE (Where deceased lived. If institution: residence
before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN

Baltimore

D. STREET ADDRESS (If rural, give location)

611 W. Baltimore Street

8. DATE OF BIRTH

Oct. 1, 1890

9. AGE (In years
last birthday)

60

11 Under 1 Year
Months: Days11 Under 24 Hours
Hours: Min.

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

14. MOTHER'S MAIDEN NAME

Jennie Butler

17. INFORMANT

ADDRESS

Records: B. C. H. 4940 Eastern Avenue

18. E 904.7 I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)(A) Bronchial Pneumonia bi Lateral and
Nephro-Sclerosis

DUE TO

INTERVAL BETWEEN
ONSET AND DEATH

4 Days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

CERTIFICATION APPROVED BY

William H. Kammmer, Jr.

per: Stanley H. Denecker
M.D.

CHIEF OR ASST. MEDICAL EXAMINER

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

Amputated leg Mid Thigh (Left)

2 Years

19A. DATE OF OPERATION

10-30-50, 11-23-50

19B. MAJOR FINDINGS OF OPERATION

left leg amputated
Insertion blount plate for left hip, for gangrene

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT WAS UNDER-
LYING OR CONTRIBUTING
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)

B. C. Hospital

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

B. C. H. 4940 Eastern Avenue

26/1/2

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

10-27-50 1 P. M.

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR?

to floor
Pt. Slipped and fell on left hip22. I hereby certify that I attended the deceased from 7-19 1950, to 11-25 1950, that I last saw the
deceased alive on 11-25 1950, and that death occurred at 9:05 A. M., from the causes and on the date stated above.

23A. SIGNATURE

R. H. Cohen

M. O.

23B. ADDRESS

4940 Eastern Avenue

23C. DATE SIGNED

12-4-50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

12/5/50

24C. NAME OF CEMETERY OR CREMATORY

Sacred Heart

24D. LOCATION (City, town, or county)

German Hill Rd.

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

William H. Kammmer, Jr.

25. FUNERAL DIRECTOR

John J. Zahya & Sons

ADDRESS

1318 Light St

VS 150

TO BE APPROVED BY MEDICAL EXAMINER

N-995.0

186a

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526

10402

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10402

Registered No.

BIRTH NO. 50-25449

1. NAME OF DECEASED
(Type or Print)

Baby Girl Ingram

2. DATE
OF
DEATH

November 25, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION

Union Memorial Hospital

C. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)4. USUAL RESIDENCE (Where deceased lived. If institution: residence
A. STATE B. COUNTY before admission)

Md.

Baltimore

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Jowson

D. STREET ADDRESS (If rural, give location)

Box 6788 5300

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

8. DATE OF BIRTH

November 25, 1950

9. AGE (In years last birthday)

H Under 1 Year Months Days

If Under 24 Hours Hours Min.

8 23

13. FATHER'S NAME

Silas M. Ingram

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

14. MOTHER'S MAIDEN NAME

Fairie Garland

17. INFORMANT

ADDRESS

18.

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

CAUSE OF DEATH

Prematurity

INTERVAL BETWEEN ONSET AND DEATH

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT WORK ☐NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from November 25, 1950, to November 25, 1950, that I last saw the deceased alive on November 25, 1950, and that death occurred at 10:45 Pm., from the causes and on the date stated above.

23A. SIGNATURE

Robert Davis Cox M.D.

M. D.

23B. ADDRESS

Union Memorial Hospital

23C. DATE SIGNED

Nov 26, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

DEC 5 - 1950

Wilmington Williams, M.D.

Harcy M. Alway

Dept of Pathology 159



635
50-10403MARIE E. MARTIN
BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10403

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <i>Marie E. Martin</i>		2. DATE OF DEATH <i>Dec 2, 1950</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <i>Baltimore City, MD</i>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MARYLAND</i> B. COUNTY <i>ANNE ARUNDEL</i>	
B. FULL NAME OF (If not in hospital or institution, give street address or location) <i>South Baltimore General Hospital</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>GREEN HAVEN, PASADENA RURAL</i>	
C. Length of stay in Baltimore <i>22 Hours</i>		D. STREET ADDRESS (If rural, give location) <i>5TH & CATHERINE ST. 5200</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Married</i>	8. DATE OF BIRTH <i>APRIL 20, 1910</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOUSE WORK</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>OWN HOME</i>	9. AGE (in years last birthday) <i>40</i>
11. BIRTHPLACE (State or foreign country) <i>Virginia</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>HERBERT S. NULL</i>		14. MOTHER'S MAIDEN NAME <i>BESSIE Y. CLARK</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>NO</i>		16. SOCIAL SECURITY NO. <i>219-30-4657</i>	
17. INFORMANT <i>Mrs. MILDRED HEAPLE</i>		ADDRESS <i>GREEN HAVEN PASADENA</i>	

CAUSE OF DEATH

18. <i>443 X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) <i>Cerebro-Vascular Hemorrhage 22 Hrs.</i>
ANTECEDENT CAUSES	(B) <i>Hypertensive Cardio-Vascular disease</i>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(C) <i>I</i>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	

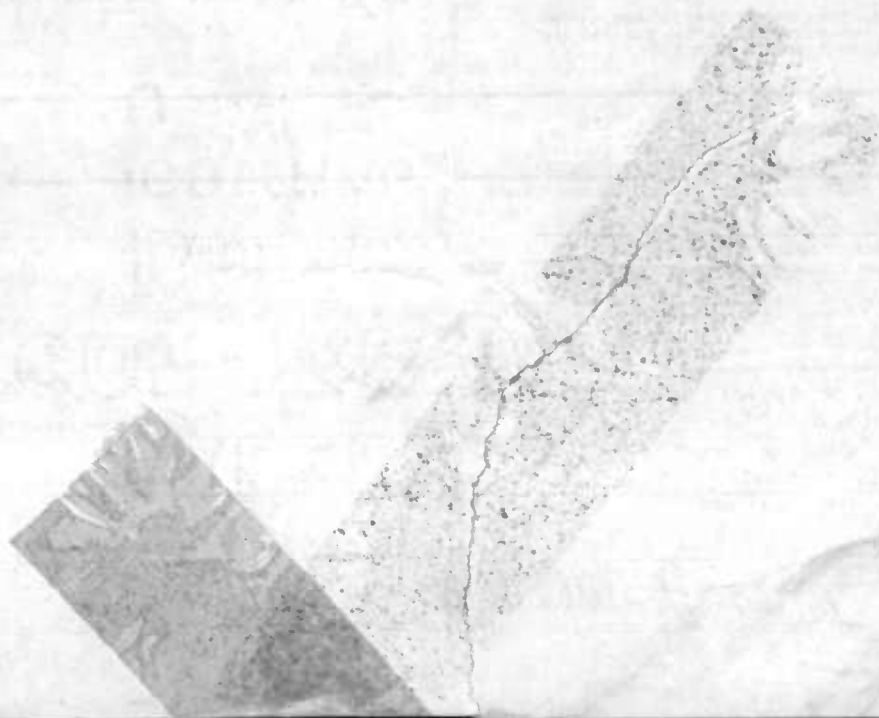
19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *Dec 1, 1950* to *Dec. 2, 1950*, that I last saw the deceased alive on *Dec 2, 1950*, and that death occurred at *6:50 P.m.*, from the causes and on the date stated above.

23A. SIGNATURE *Dr. C.D. Quirino* M.D. 23B. ADDRESS *5136H 1213 LIGOT ST* 23C. DATE SIGNED *Dec 2, 1950*

24A. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	24B. DATE <i>DEC 5, 1950</i>	24C. NAME OF CEMETERY OR CREMATORY <i>GLEN HAVEN</i>	24D. LOCATION (City, town, or county) (State) <i>GLEN BURNIE, MD</i>
DATE RECEIVED BY LOCAL REGISTRAR <i>DEC 5, 1950</i>	REGISTRAR'S SIGNATURE <i>Huntington Williams, MD</i>	25. FUNERAL DIRECTOR <i>H. Livingston</i>	ADDRESS <i>Glen Burnie Md.</i>

937



20 To be approved by Medical Examiner

50-10404 50-24557

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50-10404

BIRTH NO. 50-24557

1. NAME OF DECEASED (Type or Print) <u>George Joseph Addis</u>		2. DATE OF DEATH <u>12-2-50</u>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>City</u>	
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTE <u>Luthan Hosp. of Md.</u>		C. CITY OR TOWN (If outside corporate limits, state RURAL and give township) <u>Baltimore</u>	
D. STREET ADDRESS (If rural, give location) <u>1106 E. Hoffman</u>			
c. Length of stay in Baltimore <u>19 da</u>		Yrs. Mos. Days	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Nov. 14th., 1950</u>
9. AGE (In years last birthday) <u>0</u>		10. Under 1 Year Months: <u>0</u> Days: <u>19</u>	11. Under 24 Hours Hours: <u></u> Min. <u></u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph Addis</u>		14. MOTHER'S MAIDEN NAME <u>Doris L. Wanken</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mr. Joseph H. Addis</u>		ADDRESS <u>1106 E. Hoffman St.</u>	
18. <u>768.0</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>Septicemia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>?</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		(B) <u>Emphysematous Bronchopneumonia</u> DUE TO (C) <u>CERTIFICATION APPROVED BY DR. G. D. LUBINSKI</u> <u>per: William Edwards</u> M. D. CHIEF OR ASST. MEDICAL EXAMINER.	
19A. DATE OF OPERATION <u>2</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>noon, Dec 2, 1950</u> , to <u>4PM, Dec 2, 1950</u> that I last saw the deceased alive on <u>Dec 2, 1950</u> and that death occurred at <u>4:20 P. M.</u> , from the causes and on the date stated above.			
23A. SIGNATURE <u>M. H. Edwards</u>		23B. ADDRESS <u>Luthan Hospital of Md.</u>	
23C. DATE SIGNED <u>12-3-50</u>			
24A. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	24B. DATE <u>12-5-50</u>	24C. NAME OF CEMETERY OR CREMATORY <u>Moreland Park Cemetery</u>	24D. LOCATION (City, town, or county) (State) <u>Taylor Avenue, Balto: Co. Md.</u>
DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE <u>Washington Williams, M.D.</u>	25. FUNERAL DIRECTOR <u>George J. Ruth, Inc.</u> ADDRESS <u>-1735 Harford Avenue</u>	

DEC 5 - 1950

VS 150

107

50-10104

255

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10405

Registered No.

50-10405

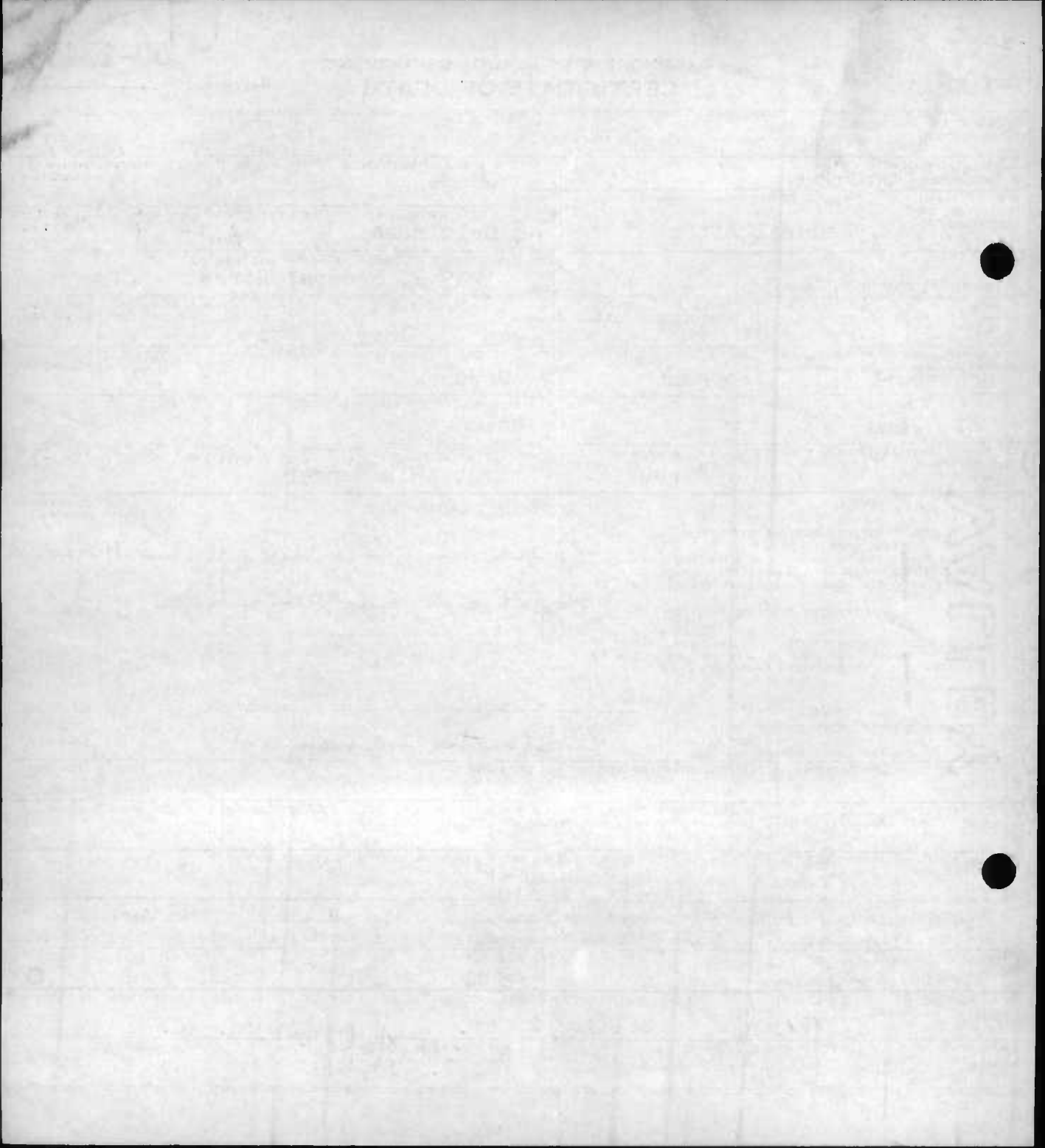
BIRTH NO.

1. NAME OF DECEASED (Type or Print) ELISABETH JAHN BUCKMAN		2. DATE OF DEATH Dec. 4, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION 1207 E. Federal Street		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore	
c. Length of stay in Baltimore 61 yrs		D. STREET ADDRESS (If rural, give location) 1207 E. Federal Street	
5. SEX F	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widow	8. DATE OF BIRTH Jan 28, 1869
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10B. KIND OF BUSINESS OR INDUSTRY at home	9. AGE (In years last birthday) 81
13. FATHER'S NAME ? Jahn		11. BIRTHPLACE (State or foreign country) Germany	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no		12. CITIZEN OF WHAT COUNTRY? USA	
16. SOCIAL SECURITY NO. none		14. MOTHER'S MAIDEN NAME Unknown	
		17. INFORMANT 1207 E. Federal Street -13 Mrs. Lulu Senner	

18. 443X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Chronic glomerulonephritis DUE TO Hypertensive C-V disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Aplastic anemia		INTERVAL BETWEEN ONSET AND DEATH 4 years 6 years 3 years
19A. DATE OF OPERATION 0	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from Jan. 7, 1943 to Dec. 3, 1950 , that I last saw the deceased alive on Dec. 3, 1950 and that death occurred at 11 m., from the causes and on the date stated above.		
23A. SIGNATURE Wm. H. Senger	23B. ADDRESS M. D. 1520 E. 33rd St.	23C. DATE SIGNED 12.4.50
24A. BURIAL, CREMATION, REMOVAL (Specify) burial	24B. DATE 12/7/50	24C. NAME OF CEMETERY OR CREMATORY Baltimore Cem.
24D. LOCATION (City, town, or county) Baltimore, Md.		25. FUNERAL DIRECTOR BERRY SANDER & SONS, INC.
26. LOCAL REGISTRAR DEC 5-1950		27. ADDRESS BALTO., 13, MD.

VS 150

121B



530
50-10406BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50-10406
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) WILLIAM SCHMIDT		2. DATE OF DEATH Dec. 3, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION 4329 Sheldon Avenue		C. CITY OR TOWN (If outside corporate limits, write full name and give township) Baltimore	
C. Length of stay in Baltimore Life		D. STREET ADDRESS (If rural, give location) 4329 Sheldon Avenue	
5. SEX M	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widower	8. DATE OF BIRTH July 14, 1887
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bottling Mach. Operator - Brewery		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
13. FATHER'S NAME Philip Schmidt		12. CITIZEN OF WHAT COUNTRY? USA	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) yes		16. SOCIAL SECURITY NO. 214-14-0916	
17. INFORMANT 3444 Cardenas Ave. Mrs. Sophie Weinmann			

18. **163X**
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) **Cancer of lung**
DUE TOINTERVAL BETWEEN ONSET AND DEATH
about 6 months

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)
DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

MEDICAL CERTIFICATION

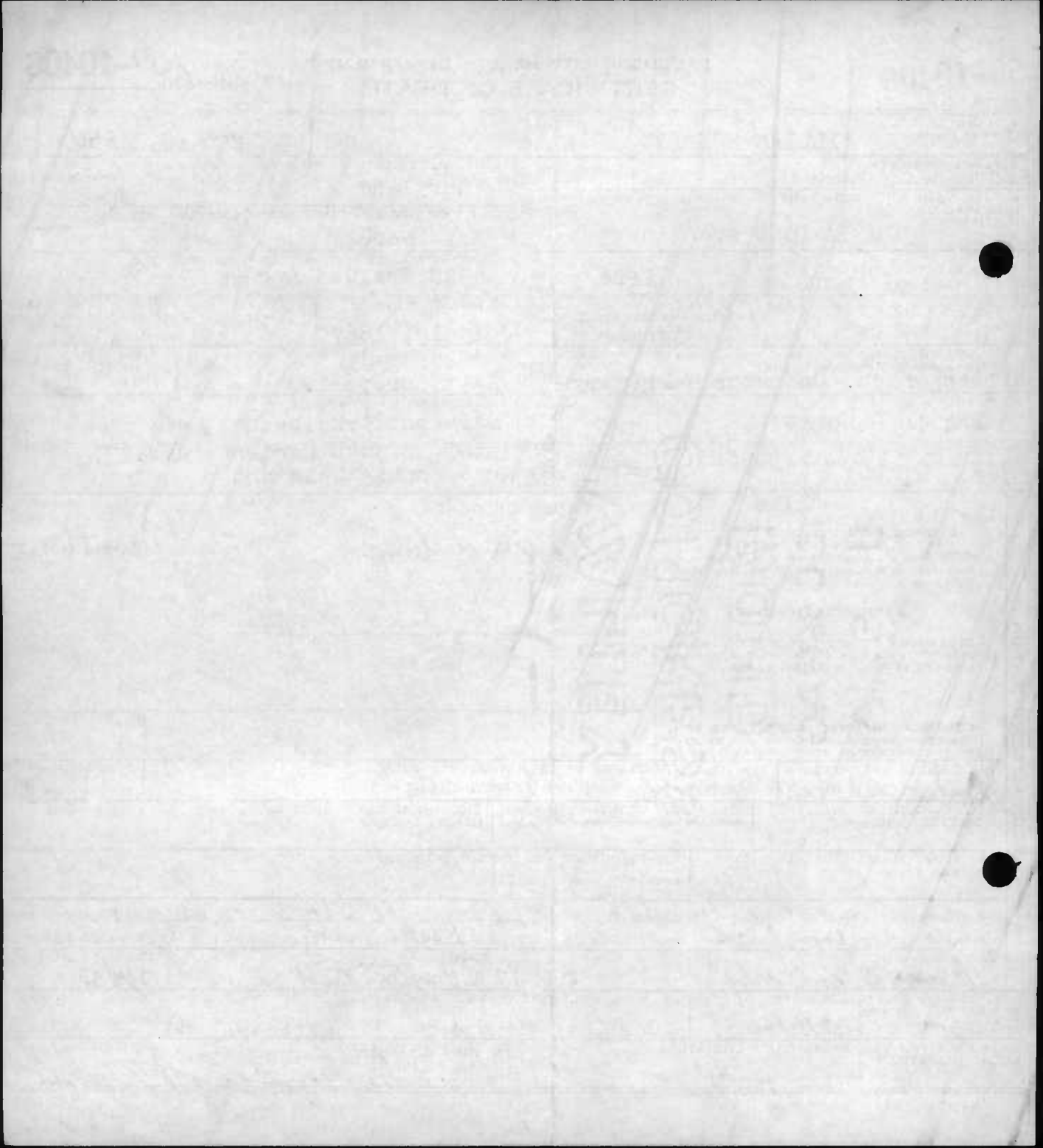
19A. DATE OF OPERATION Bladder excised 10/2/50		19B. MAJOR FINDINGS OF OPERATION Examination showed Cancer cells -		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 9/8 , 1950, to 12/3 , 1950, that I last saw the deceased alive on 12/3 , 1950, and that death occurred at 1:30 p.m. , from the causes and on the date stated above.					
23A. SIGNATURE Nancy D. McCarty		23B. ADDRESS 37 W. Preston Street		23C. DATE SIGNED 12/4/50	
24A. BURIAL, CREMATION, REMOVAL (Specify) burial		24B. DATE 12/6/50		24C. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery	
				24D. LOCATION (City, town, or county) (State) Baltimore, Md.	

DATE RECEIVED BY LOCAL REGISTRAR DEC 5-1950		REGISTRAR'S SIGNATURE W. Williams		25. FUNERAL DIRECTOR HENRY SANDER & SONS, INC.	
				ADDRESS BALTO., 13, MD.	

VS 150

69046

47D



345
50-10407BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50-10407

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

JOHN G CATLIN

2. DATE
OF
DEATH

DEC. 4, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

425 WESTGATE RD.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

MD.

B. COUNTY

C. CITY OR TOWN

BALTIMORE

D. STREET ADDRESS (If rural, give location)

425 WESTGATE RD.

C. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

WIDOWED

8. DATE OF BIRTH

DEC. 27, 1856

9. AGE (In years
last birthday)

93

If Under 1 Year
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

RETIRED

10B. KIND OF BUSINESS OR
INDUSTRY

?

11. BIRTHPLACE (State or foreign country)

MD.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

EDWARD CATLIN

14. MOTHER'S MAIDEN NAME

SARAH WHITE

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.
216-12-1872

17. INFORMANT

ADDRESS 423

MRS. A. KATHRYN STOKES - WESTGATE RD.

18. 420.1

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A)

Coronary Thrombosis

1 da.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

Coronary Atherosclerosis

10 years

(C)

II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH21B. PLACE OF INJURY (e.g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec 10, 1948, to Dec. 4, 1950, that I last saw the deceased alive on Dec. 4, 1950, and that death occurred at 3:00 p.m., from the causes and on the date stated above.

23A. SIGNATURE

William K. Gallagher

M. O.

23B. ADDRESS

Catonville-28, Md.

23C. DATE SIGNED

12-4-50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

BURIAL

24B. DATE

12/7/50

24C. NAME OF CEMETERY OR CREMATORY

SUNNY RIDGE

24D. LOCATION (City, town, or county)

CRISFIELD, MD

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

DEC 5 - 1950

REGISTRAR'S SIGNATURE

William K. Gallagher

25. FUNERAL DIRECTOR

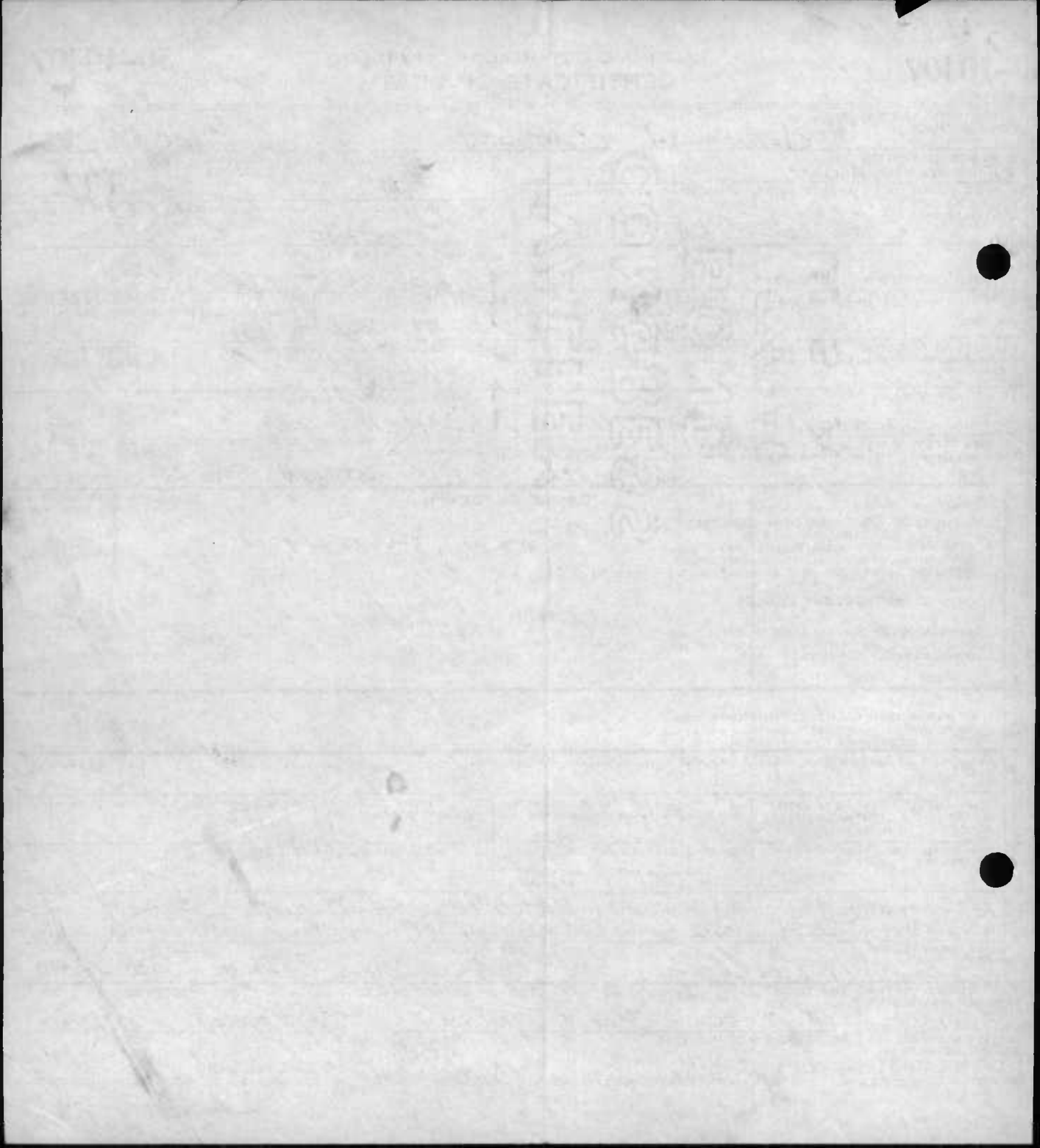
Bradshaw Funeral Home -

ADDRESS

Crisfield, Md.
94a

VS 150

MEDICAL CERTIFICATION



620
50-10408Schwarz
BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50-10408
Registered No.

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Thomas A Schwarz</i>		2. DATE OF DEATH <i>Dec 4-50</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <i>1671 Clifton Ave</i>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Baltimore Md</i> B. COUNTY <i>8-63</i>			
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>No</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>8-63</i>			
C. Length of stay in Baltimore <i>Life</i>		D. STREET ADDRESS (If rural, give location) <i>1671 Clifton Ave</i>			
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Married</i>	8. DATE OF BIRTH <i>March 25 1875</i>	9. AGE (in year, last birthday) <i>75</i>	10. Under 1 Year Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Tool Creek</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Baltimore Ave</i>		11. BIRTHPLACE (State or foreign country) <i>Baltimore</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>Thomas A Schwarz</i>		14. MOTHER'S MAIDEN NAME <i>I don't know</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>No</i>		17. INFORMANT ADDRESS <i>Mrs. Hilda E Schwarz 1671 Clifton</i>	
18. <i>420.1</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH (A) <i>Coronary Embolism</i> <i>Angina Pectoris</i> <i>Arterio Sclerosis</i> <i>Hypertension</i> (B) <i>Chronic Intestinal Atherosclerosis</i> (C) <i>Chronic Intestinal Atherosclerosis</i>		INTERVAL BETWEEN ONSET AND DEATH <i>20 min</i> <i>2 hrs</i> <i>2 hrs</i> <i>2 hrs</i> <i>2 hrs</i>	
19A. DATE OF OPERATION <i>No</i>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>Dec 3</i> , 19 <i>50</i> , to <i>Dec 4</i> , 19 <i>50</i> , that I last saw the deceased alive on <i>Dec 4</i> , 19 <i>50</i> , and that death occurred at <i>5 P.</i> m., from the causes and on the date stated above.					
23A. SIGNATURE <i>S. F. A. Stevens</i>		23B. ADDRESS M. D. <i>2878 Harford Rd</i>		23C. DATE SIGNED <i>12-5-50</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>Dec 7, 1950</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Parkwood</i>	
24D. LOCATION (City, town, or county) (State) <i>Balt</i>		24E. FUNERAL DIRECTOR <i>A. Howard & Sons</i>		24F. ADDRESS <i>1400 S. Charles</i>	
DATE RECEIVED BY LOCAL REGISTRAR <i>DEC 5-1950</i>		REGISTRAR'S SIGNATURE <i>W. H. Williams, M.D.</i>		VS 150	

131a



325
50-10409

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50-10409

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Ruth Watkins

2. DATE
OF
DEATH

Dec 2, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION

840 Hampson St

C. Length of stay in Baltimore

Yrs.
Mos.
Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

840 Hampson St

5. SEX

F

6. COLOR OR RACE

C

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

M

8. DATE OF BIRTH

Dec 12, 1900

9. AGE (In years last birthday)

49 50

If Under 1 Year
Months Days

If Under 24 Hours
Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Home wife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Md

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Rebdee Brooks

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Carroll Watkins 840 Hampson St

1B. 421.4

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

DUE TO

Chronic Thrombosis

INTERVAL BETWEEN
ONSET AND DEATH

2 1/2 yrs.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

Obesity + malaria

2 yrs.

(C)

II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH

21B. PLACE OF INJURY (e.g., in or
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec 1, 1950, to Dec. 2, 1950, that I last saw the deceased alive on Dec 2, 1950, and that death occurred at 6 P. m., from the causes and on the date stated above.

23A. SIGNATURE

Michael A. Hanna M.D.

23B. ADDRESS

1820 Cedar Place

23C. DATE SIGNED

Dec. 4, 1950

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

12-6-50

24C. NAME OF CEMETERY OR CREMATORY

West Calvary

24D. LOCATION (City, town, or county)

Md

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

DEC 5 - 1950

REGISTRAR'S SIGNATURE

Frederick W. Williams, Jr.

25. FUNERAL DIRECTOR

ADDRESS

George L. Kelson 1303 Prentiss St

VS 150

921

MEDICAL CERTIFICATION

1820 Cutaway Pl

Diagrams

362
50-10410
BIRTH NO.

PATTERSON
BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10410
Registered No.

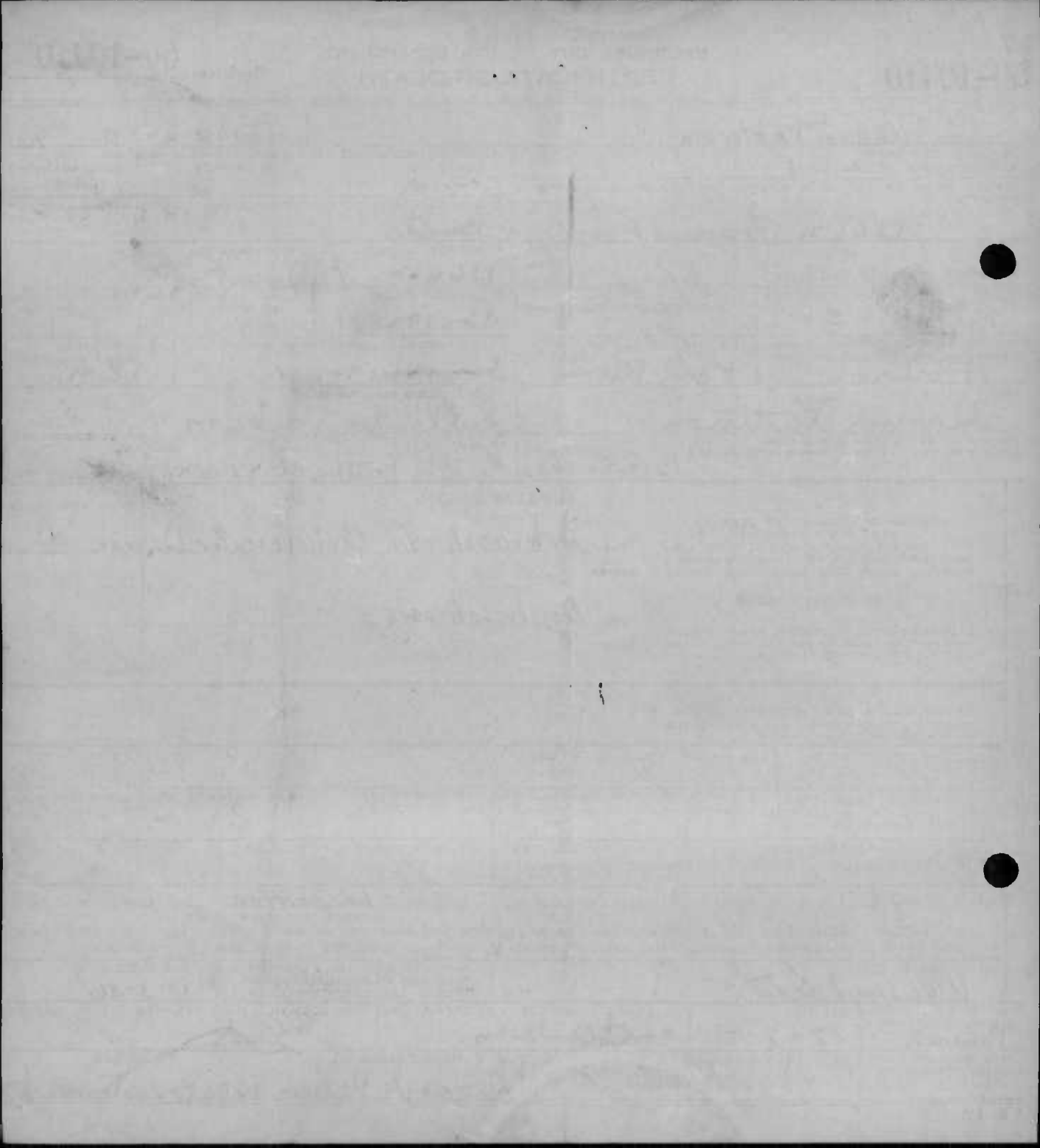
1. NAME OF DECEASED (Type or Print) <i>William L. Patterson</i>			2. DATE OF DEATH <i>12-2-50</i>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>md</i> B. COUNTY <i>15-01</i>		
B. FULL NAME OF (If not in hospital or institution, give street address or location) <i>1366 n. Fremont ave</i>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Balto</i>		
D. STREET ADDRESS (If rural, give location) <i>1366 n. Fremont ave</i>			E. LENGTH OF STAY IN BALTIMORE <i>Life</i>		
5. SEX <i>M</i>	6. COLOR OR RACE <i>C</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>S</i>	8. DATE OF BIRTH <i>Jan 14, 1881</i>	9. AGE (In years last birthday) <i>69</i>	10. Under 1 Year Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Porter</i>			10B. KIND OF BUSINESS OR INDUSTRY <i>Pool Room</i>		
11. BIRTHPLACE (State or foreign country) <i>md</i>			12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME <i>Edward Patterson</i>			14. MOTHER'S MAIDEN NAME <i>Lusinda Jackson</i>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <i>219-20-7490</i>		
17. INFORMANT <i>Edith Patterson</i>			ADDRESS <i>1366 n. Fremont ave</i>		

18. <i>442X</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH	INTERVAL BETWEEN ONSET AND DEATH
(A) <i>Arteriosclerotic Cardiovascular Disease</i>			
ANTECEDENT CAUSES			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) <i>Nephrosclerosis</i>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		(C)	

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		

22. I certify that I took charge of the remains described above, held an *Inspection* thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE <i>William V. Smith</i>		23B. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> M.D. MEDICAL INVESTIGATOR <input type="checkbox"/>		23C. DATE SIGNED <i>12-3-50</i>
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>12-7-50</i>	24C. NAME OF CEMETERY OR CREMATORY <i>mt Auburn.</i>	24D. LOCATION (City, town, or county) (State) <i>md</i>	
DATE RECEIVED BY LOCAL REGISTRAR <i>DEC 5 1950</i>		REGISTRAR'S SIGNATURE <i>George S. Nelson</i>		25. FUNERAL DIRECTOR <i>George S. Nelson</i>
				ADDRESS <i>1303 Presstons</i>



650
50-10411BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50-10411

BIRTH NO.

1. NAME OF DECEASED (Type or Print) JOHN EARL GREEN			2. DATE OF DEATH December 4, 1950		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE Maryland B. COUNTY		
B. FULL NAME OF (If not in hospital or institution, give street address or location) 2642 Kirk Avenue			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore		
D. STREET ADDRESS (If rural, give location) 2642 Kirk Avenue			E. LENGTH OF STAY IN BALTIMORE Yrs. _____ Mos. _____ Days _____		
5. SEX male	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH 4-9-96	9. AGE (In years last birthday) 54	10. Under 1 Year Months: _____ Days: _____
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Distributor			10B. KIND OF BUSINESS OR INDUSTRY Biro Mfg. Co		
11. BIRTHPLACE (State or foreign country) Ohio			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Vernon E. Green			14. MOTHER'S MAIDEN NAME Mary		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) World War 1			16. SOCIAL SECURITY NO.		
17. INFORMANT Mrs Helen Green			ADDRESS 2642 Kirk Ave		

18. 330X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Ruptured aneurysm of circle of Willis DUE TO with subdural and subarachnoid hemorrhage	INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) _____ (C) _____	

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	

22. I certify that I took charge of the remains described above, held an Partial autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE <i>William V. Smith</i>		23B. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> MEDICAL INVESTIGATOR <input type="checkbox"/>		23C. DATE SIGNED Dec. 4, 1950	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-7-50		24C. NAME OF CEMETERY OR CREMATORY National	
24D. LOCATION (City, town, or county) (State) Baltimore Md		25. FUNERAL DIRECTOR <i>Lilly & Zick</i>		ADDRESS 403 S. Wolfe Str.	
DATE RECEIVED BY LOCAL REGISTRAR DEC 5-1950		REGISTRAR'S SIGNATURE <i>William V. Smith</i>		VS 151	

29065

96 ✓

**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

Registered No.

50-10412

656
50-10412
BIRTH NO.

1. NAME OF DECEASED (Type or Print) <i>Margaret E. Cromer</i>			2. DATE OF DEATH <i>12-2-50</i>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>MD</i> B. COUNTY		
B. FULL NAME OF (If not in hospital or institution, give street address or location) <i>Hopkins Hospital</i>			C. CITY OR TOWN (If outside corporate limits, write R.U.A.L. and give township) <i>Baltimore 19-21</i>		
D. STREET ADDRESS (If rural, give location) <i>1327 Edmondson ave</i>			E. LENGTH OF STAY IN BALTIMORE <i>Life</i>		
4. SEX <i>Female</i>	5. COLOR OR RACE <i>Col</i>	6. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Married</i>	7. DATE OF BIRTH <i>3-17-1919</i>		8. AGE (In years last birthday) <i>31</i>
9. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>			10. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Baltimore</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			13. FATHER'S NAME <i>Bernard Marshall</i>		
14. MOTHER'S MAIDEN NAME <i>Anna C. Addison</i>			15. INFORMANT <i>Ernest Cromer</i>		
16. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)			17. SOCIAL SECURITY NO.		

18. <i>651.2</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (<i>651.2</i>) <i>Peritonitis - Criminal Abortion</i>		INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		DUE TO <i>Rupture of Uterus</i>		
		DUE TO <i>Uterine Hemorrhage</i>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		<i>Pregnancy (3 mos.)</i>		

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		

22. I certify that I took charge of the remains described above, held an *Autopsy* thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐.

23A. SIGNATURE <i>William V. Lovitt</i>		23B. CHIEF MEDICAL EXAMINER..... ASSISTANT MEDICAL EXAMINER..... M.D. MEDICAL INVESTIGATOR.....		23C. DATE SIGNED <i>12-3-50</i>
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>12-8-1950</i>	24C. NAME OF CEMETERY OR CREMATORY <i>Calvary Cem. A. A. C.</i>		24D. LOCATION (City, town, or county) (State) <i>MD</i>
DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE <i>Huntington Williams</i>	25. FUNERAL DIRECTOR <i>Payner Sanders</i> ADDRESS <i>1412 E. Preston St</i>		

EC 5-1950
VS 151

MEDICAL CERTIFICATION

50-10115

CONFIDENTIAL

10

03-1-71

10

400
50-10413BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10413

Registered No.

1. NAME OF DECEASED (Type or Print) <i>John Nolley</i>		2. DATE OF DEATH <i>Dec. 3, 1950</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md</i> B. COUNTY <i>12-03</i>	
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>THE JOHNS HOPKINS HOSPITAL</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore</i>	
c. Length of stay in Baltimore Yrs. <i>53</i> Mos. <i>12</i> Days <i>03</i>		D. STREET ADDRESS (If rural, give location) <i>2446 Brentwood Ave</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>Colored</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH <i>5-15-94</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Laborer</i>		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (in years last birthday) <i>56</i>
11. BIRTHPLACE (State or foreign country) <i>Virginia</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Albert Nolley</i>		14. MOTHER'S MAIDEN NAME <i>Ann?</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>THE JOHNS HOPKINS HOSPITAL</i>		ADDRESS	

18. <i>57031</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Uremia</i>	CAUSE OF DEATH (A) <i>Uremia</i> DUE TO	INTERVAL BETWEEN ONSET AND DEATH <i>1 wk</i>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <i>Renal failure - peritonitis</i>	(B) <i>Renal failure - peritonitis</i> DUE TO <i>Sigmoid Volvulus</i>	<i>2 wk</i>
(C) <i>Sigmoid Volvulus</i>		<i>?</i>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Antonie's syndrome</i>		

19A. DATE OF OPERATION <i>11-13-50/11-24-50</i>	19B. MAJOR FINDINGS OF OPERATION <i>① Sigmoid Volvulus ② Peritonitis</i>	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *11/13*, 19*50*, to *12/3*, 19*50*, that I last saw the deceased alive on *12/3*, 19*50*, and that death occurred at *8:15* a. m., from the causes and on the date stated above.

23A. SIGNATURE <i>Ruane E. Menell</i> M. D.	23B. ADDRESS <i>THE JOHNS HOPKINS HOSPITAL</i>	23C. DATE SIGNED
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24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>12-6-1950</i>	24C. NAME OF CEMETERY OR CREMATORY <i>Mt Calvary Cem A. A. Co Md</i>	24D. LOCATION (City, town, or county) (State) <i>122 B</i>
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DATE RECEIVED BY LOCAL REGISTRAR <i>DEC 5 - 1950</i>	REGISTRAR'S SIGNATURE <i>Antonie's syndrome</i>	25. FUNERAL DIRECTOR <i>Rayner Sanders</i>	ADDRESS <i>97099 14 12 E Preston St</i>
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432
50-10414

PC 7310

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10414

Registered No. 536790

BIRTH NO.

1. NAME OF DECEASED (Type or Print) **Maudie Fields** 2. DATE OF DEATH **12-3-50**

3. PLACE OF DEATH: A. Baltimore City, Maryland **Sinai Hospital** 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE **1528 Entaw Place** B. COUNTY **14-12**

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) **1528 Entaw Place** C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township) **Balt Md**

D. STREET ADDRESS (If rural, give location) **1528 Entaw Place**

Length of stay in Baltimore **2 years** Yrs. Mos. Days

5. SEX **Female** 6. COLOR OR RACE **White** 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) **married** 8. DATE OF BIRTH **May 7 1920** 9. AGE (In years last birthday) **30** 10. Under 1 Year Months: Days **5 25** 11. Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **House Wife** 10B. KIND OF BUSINESS OR INDUSTRY **House Wife** 11. BIRTH PLACE (State or foreign country) **Lynchburg Va** 12. CITIZEN OF WHAT COUNTRY? **USA**

13. FATHER'S NAME **John O Reynolds** 14. MOTHER'S MAIDEN NAME **Bertha Ellington**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) **no** (If yes, give war or dates of service) **no** 16. SOCIAL SECURITY NO. **228-09-7609** 17. INFORMANT **Ms. Edward B Fields** ADDRESS **1528 Entaw**

18. **678X** CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) **Air Embolus during delivery of the second of twins (678)** DUE TO (A) **Second of twins (678)** ANTECEDENT CAUSES DUE TO (B) **Pregnancy (Full term)** DUE TO (C) **over**

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION 19B. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? YES ☒ NO ☐

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ 21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an **Autopsy** thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐.

23A. SIGNATURE **William V. Smith** 23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ M.D. 23C. DATE SIGNED **12-3-50**

24A. BURIAL, CREMATION, REMOVAL (Specify) **Burial** 24B. DATE **Dec 7 1950** 24C. NAME OF CEMETERY OR CREMATORY **Penel Baptist Church** 24D. LOCATION (City, town, or county) (State) **Lynchburg Va**

DATE RECEIVED BY LOCAL REGISTRAR REGISTRAR'S SIGNATURE 25. FUNERAL DIRECTOR **David Sordheim** ADDRESS **1528 Entaw**

Stillbirth #36790 - 12/3/50

200
10-10415
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10415
Registered No.

1. NAME OF DECEASED (Type or Print) CHARLES GOUGH, JR.			2. DATE OF DEATH December 2, 1950		
3. PLACE OF DEATH: A. Baltimore City, Maryland B. FULL NAME OF HOSPITAL OR INSTITUTION Franklin Square Hospital C. Length of stay in Baltimore Yrs. Mos. Days			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1111 W. Fairmount Avenue		
5. SEX Male	6. COLOR OR RACE Colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday) 26	10. Under 1 Year Months Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fruit handler		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Charles Boston			14. MOTHER'S MAIDEN NAME Martha Hamlet		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) yes		16. SOCIAL SECURITY NO. WW II	17. INFORMANT ADDRESS Mrs. Martha Gough, 1111 W. Fairmount Ave.		

18. E987X, DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Stab wound of chest and heart with pericardial hemorrhage CAUSE OF DEATH (A) Stab wound of chest and heart with pericardial hemorrhage INTERVAL BETWEEN ONSET AND DEATH	19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) (C)
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) Friend's home		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 12 S. Schroeder Street	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY December 2, 1950 3:00A.m.		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? Stabbed with a knife	

22. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐.

23A. SIGNATURE William V. Smith		23B. CHIEF MEDICAL EXAMINER..... M.D. ASSISTANT MEDICAL EXAMINER..... MEDICAL INVESTIGATOR.....		23C. DATE SIGNED Dec. 2, 1950	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial	24B. DATE 12-6-1950	24C. NAME OF CEMETERY OR CREMATORY Baltimore National	24D. LOCATION (City, town, or county) (State) Baltimore Md.		
DATE RECEIVED BY LOCAL REGISTRAR DEC 5-1950		REGISTRAR'S SIGNATURE William V. Smith		25. FUNERAL DIRECTOR Mrs. Katie R. Williams	
				ADDRESS 322 N Schroeder St	

52
50-10416

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10416

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) WILLIE MAE LOWERY EVANS			2. DATE OF DEATH December 2, 1950		
3. PLACE OF DEATH: a. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Maryland b. COUNTY		
b. FULL NAME OF HOSPITAL OR INSTITUTION Provident Hospital			c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore		
c. Length of stay in Baltimore Yrs. _____ Mos. _____ Days _____			d. STREET ADDRESS (If rural, give location) 1322 N. Fremont Avenue		
5. SEX Female	6. COLOR OR RACE Colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH July 25, 1950		9. AGE (In years last birthday) 25
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Clover, South Carolina		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME William Lowery			14. MOTHER'S MAIDEN NAME Vancie Starnes		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT Mamie Lowery		
			ADDRESS 821 N. Arlington Ave		

18. E971-7 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Phosphorous poisoning DUE TO (A) _____ (B) _____ (C) _____		INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) _____ (C) _____		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) home	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 1322 N. Fremont Avenue		
21D. TIME (Month) (Day) (Year) (Hour) December 1, 1950 5:30 PM	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21F. HOW DID INJURY OCCUR? Ingestion of Rat & Roach Paste		

22. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion, resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐.

23A. SIGNATURE <i>William V. ...</i>		23B. CHIEF MEDICAL EXAMINER..... M.D. ASSISTANT MEDICAL EXAMINER..... MEDICAL INVESTIGATOR.....		23C. DATE SIGNED 12-4-50
24A. BURIAL, CREMATION, REMOVAL (Specify) Shipped	24B. DATE 12-6-1950	24C. NAME OF CEMETERY OR CREMATORY Gastonia N.C.	24D. LOCATION (City, town, or county) (State) Gastonia N.C.	
DATE RECEIVED BY LOCAL REGISTRAR DEC 5-1950	REGISTRAR'S SIGNATURE <i>William V. ...</i>	25. FUNERAL DIRECTOR Mrs. Katie B. Williams		ADDRESS 322 N. Schuylkill

MEDICAL CERTIFICATION

300
50-10417BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50-10417

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Caroline Rose Scott

2. DATE OF DEATH
December 3, 1950.

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

1504 Madison Ave.

Yrs.
Mos.
Days

C. Length of stay in Baltimore

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland.

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore 14-02

D. STREET ADDRESS (If rural, give location)

1504 Madison Ave.

5. SEX

Female

6. COLOR OR RACE

C

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Widow

8. DATE OF BIRTH

December 8, 1876 73

9. AGE (In years last birthday)

If Under 1 Year

Months: Days

If Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Lonsville, Ga.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Jack Backus

14. MOTHER'S MAIDEN NAME

Rose ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Mr. Sherman Scott, 20532 Division St.

1B. 446 X I

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A)

DUE TO

Chronic Interstitial Nephritis
Hypertension

4 7/10

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from September 1950 to Dec 3, 1950 that I last saw the deceased alive on Dec 19, 1950, and that death occurred at 12:40 p.m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

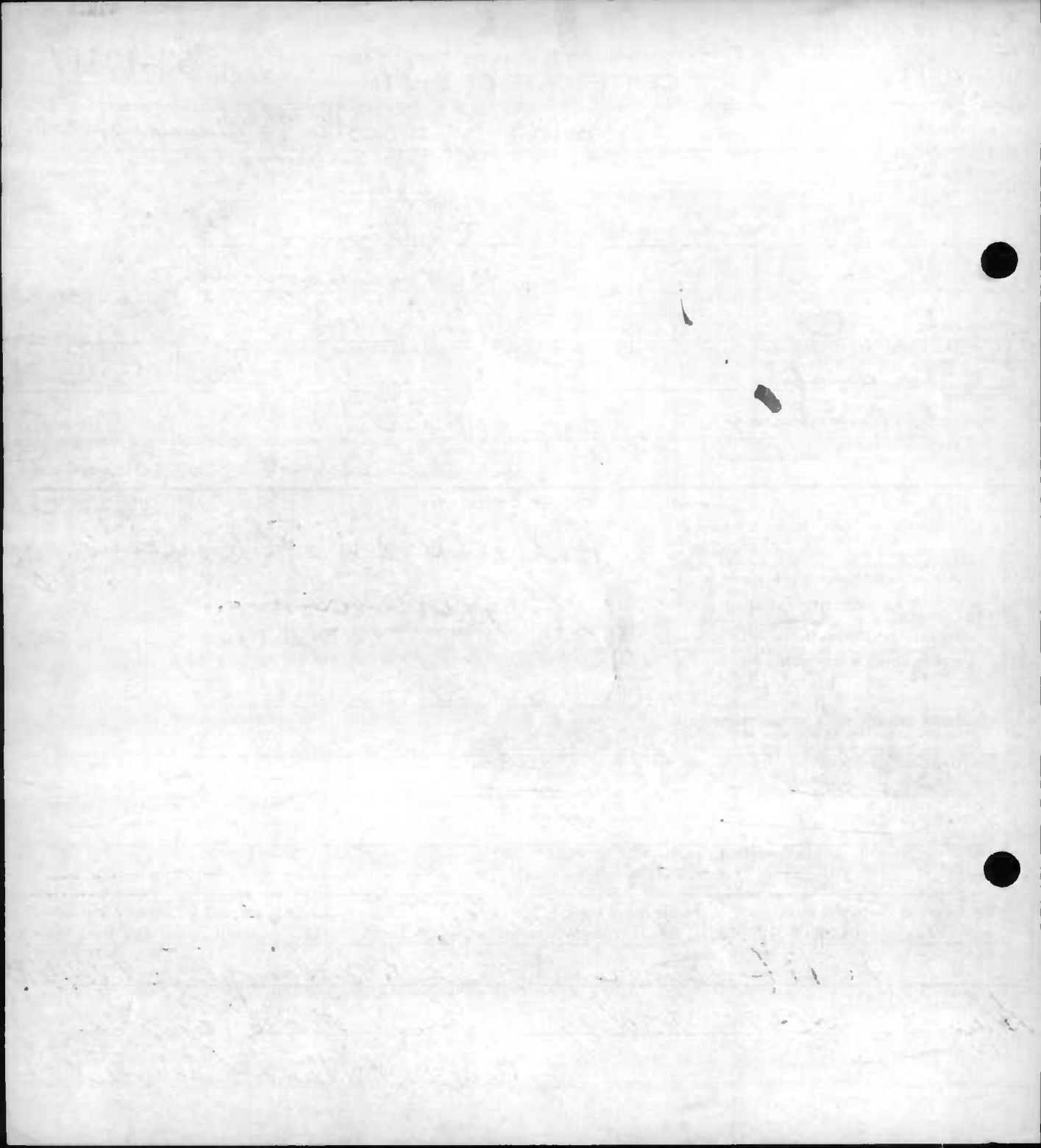
24D. LOCATION (City, town, county) (State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS



000
-10418
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10418
Registered No.

1. NAME OF DECEASED (Type or Print) OLIVER LEE			2. DATE OF DEATH December 4, 1950		
3. PLACE OF DEATH: a. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Maryland b. COUNTY		
b. FULL NAME OF HOSPITAL OR INSTITUTION Mercy Hospital			c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore		
c. Length of stay in Baltimore			d. STREET ADDRESS (If rural, give location) 1015 St. Paul Street		
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) single	8. DATE OF BIRTH July 7, 1899	9. AGE (In years last birthday) 51	10. Under 1 Year Months: Days: Hours: Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Couterman		10b. KIND OF BUSINESS OR INDUSTRY Restaurant	11. BIRTHPLACE (State or foreign country) Brooklyn, New York		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Joseph Lee			14. MOTHER'S MAIDEN NAME Mildred Shuttleworth		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS Ruth M. Lee, 240 Winthrop St., Brooklyn, N.Y.		

18. 521X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Pulmonary abscesses and fibrosis (A) XXXXXX	CAUSE OF DEATH Pulmonary abscesses and fibrosis	INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) Fibrino purulent pleurisy, left DUE TO (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED m. WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	

22. I certify that I took charge of the remains described above, held an **Autopsy** thereon and from **Autopsy, Inspection or Inquiry** the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: **natural causes** ☒, **accident** ☐, **suicide** ☐, **homicide** ☐, **undetermined** ☐.

23A. SIGNATURE Stanley H. Durlacher M.D.		23B. CHIEF MEDICAL EXAMINER..... <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER..... <input checked="" type="checkbox"/> MEDICAL INVESTIGATOR..... <input type="checkbox"/>		23C. DATE SIGNED Dec. 5, 1950	
24A. BURIAL, CREMATION, REMOVAL (Specify) removal	24B. DATE 12/5/50	24C. NAME OF CEMETERY OR CREMATORY Cypress Hill	24D. LOCATION (City, town, or county) (State) Brooklyn, New York		
DATE RECEIVED BY LOCAL REGISTRAR DEC 5-1950		REGISTRAR'S SIGNATURE Walter H. Williams		25. FUNERAL DIRECTOR ADDRESS Wm. Cook, Inc. 1217 St. Paul Street	

10-10-19

STATE OF TEXAS
COUNTY OF DALLAS

BEFORE ME, the undersigned authority, on this _____ day of _____, 19____, personally appeared _____, known to me to be the person whose name is subscribed to the foregoing instrument, and acknowledged to me that he executed the same for the purposes and consideration therein expressed.

My commission expires _____.

Notary Public in and for the State of Texas

**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

Registered No.

50-10419

BIRTH NO. 30-19326

1. NAME OF DECEASED (Type or Print) KATHLEEN JONES			2. DATE OF DEATH December 4, 1950		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY		
5. FULL NAME OF (If not in hospital or institution, give street address or location) 524 S. Conklin Street			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore		
6. LENGTH OF STAY IN BALTIMORE Yrs. _____ Mos. _____ Days _____			D. STREET ADDRESS (If rural, give location) 524 S. Conklin Street		
5. SEX female	6. COLOR OR RACE colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) S.	8. DATE OF BIRTH 9-9-50 10/19/50		9. AGE (In years last birthday) 1 23 15
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Balto City
13. FATHER'S NAME Lura Jones			14. MOTHER'S MAIDEN NAME Ellen Jefferson		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
17. INFORMANT Ellen Jones - 524 W. Barr St			ADDRESS		

18. 491X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) Bronchopneumonia DUE TO		INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES (B) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		

22. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐.

23A. SIGNATURE *William H. Brown* 23B. CHIEF MEDICAL EXAMINER..... ☒ ASSISTANT MEDICAL EXAMINER..... ☒ MEDICAL INVESTIGATOR..... ☐ 23C. DATE SIGNED **Dec. 4, 1950**

24A. BURIAL, CREMATION, REMOVAL (Specify) **Burial** 24B. DATE **12/4/50** 24C. NAME OF CEMETERY OR CREMATORY **Int. Auburn Ct** 24D. LOCATION (City, town, or county) (State) **Balto City**

DATE RECEIVED BY LOCAL REGISTRAR **DEC 5 - 1950** REGISTRAR'S SIGNATURE *William H. Brown* 25. FUNERAL DIRECTOR **108-2** ADDRESS **J. L. Brown & Son - Montgomery St**

MEDICAL CERTIFICATION

630

50-10420

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50-10420

BIRTH NO. 50-09469

1. NAME OF DECEASED (Type or Print) KENNETH		2. DATE OF DEATH December 4, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION Franklin Square Hospital		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore	
C. Length of stay in Baltimore Yrs. _____ Mos. _____ Days _____		D. STREET ADDRESS (If rural, give location) 217 N. Calhoun Street	
5. SEX Male	6. COLOR OR RACE Colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) SINGLE	8. DATE OF BIRTH 5/14/50
9. AGE (In years last birthday) 6		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	11. BIRTHPLACE (State or foreign country) Baltimore, City
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME Rudolph Howard	
14. MOTHER'S MAIDEN NAME Margaret Knight		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Margaret Howard-217 N. Calhoun St	

18. 491X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Antecedent Causes DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	CAUSE OF DEATH (A) Bronchopneumonia DUE TO (B) DUE TO (C)	INTERVAL BETWEEN ONSET AND DEATH
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19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE <i>William V. [Signature]</i>	23B. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> MEDICAL INVESTIGATOR <input checked="" type="checkbox"/>	23C. DATE SIGNED 12-4-50
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial	24B. DATE 12/6/50	24C. NAME OF CEMETERY OR CREMATORY Mount Auburn Ct
24D. LOCATION (City, town, or county) (State) Baltimore, City.	25. FUNERAL DIRECTOR 106-W ADDRESS J. L. Brown & Son - Montgomery St	

DATE RECEIVED BY LOCAL REGISTRAR DEC 5-1950	REGISTRAR'S SIGNATURE <i>[Signature]</i>	107 ✓
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10-11-10

WITNESS FOR THE DEATH

TESTIFICATE OF DEATH

10-11-10

Name of Deceased		Age		Sex		Race		Religion		Marital Status		Occupation		Date of Death		Place of Death		Cause of Death		Time of Death		Signature of Physician		Signature of Witness		Signature of Coroner	

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50-10421BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50-10421
Registered No.

BIRTH NO.		
1. NAME OF DECEASED (Type or Print) ELIZABETH G. COVERDALE		2. DATE OF DEATH Dec. 4, 1950
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY
B. FULL NAME OF HOSPITAL OR INSTITUTION 1934 E. 31st St.		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
C. Length of stay in Baltimore Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) 1934 E. 31st St.
5. SEX female	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) widowed
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY at Home
13. FATHER'S NAME James Graham		14. MOTHER'S MAIDEN NAME Annie Crawford
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) no		16. SOCIAL SECURITY NO.
17. INFORMANT Mr. Arthur S. Coverdale - 1934 E. 31st St.		ADDRESS
18. 723.0 1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) Broncho Pneumonia 3 days DUE TO ANTECEDENT CAUSES (B) Recumbent ulcers back 30 days DUE TO (C) Hypertrophic Arthritis 5 years INTERVAL BETWEEN ONSET AND DEATH II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. HOW DID INJURY OCCUR?
21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
22. I hereby certify that I attended the deceased from June, 1948 to 12-4-1950 that I last saw the deceased alive on 11-27-1950. and that death occurred at 4:30 P.M., from the causes and on the date stated above.		
23A. SIGNATURE E. W. Peake		23B. ADDRESS 4508 Hampden Rd.
23C. DATE SIGNED 12-5-52		
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/6/50
24C. NAME OF CEMETERY OR CREMATORY Woodlawn Cem.		24D. LOCATION (City, town, or county) (State) Woodlawn, Md.
DATE RECEIVED BY LOCAL REGISTRAR DEC 5 - 1950		25. FUNERAL DIRECTOR J. J. Lickens & Sons - Balto Md.
REGISTRAR'S SIGNATURE Wm. J. Williams		ADDRESS

MEDICAL CERTIFICATION

VS 150

107

10-1-1954

RECEIVED
FEDERAL BUREAU OF INVESTIGATION
U. S. DEPARTMENT OF JUSTICE

10-1-1954

TO : SAC, NEW YORK (100-100000)

FROM : SAC, NEW YORK (100-100000)

SUBJECT: [Illegible]

RE: [Illegible]

DATE: 10-1-1954

BY: [Illegible]

FOR: [Illegible]

THROUGH: [Illegible]

BY: [Illegible]

FOR: [Illegible]

THROUGH: [Illegible]

BY: [Illegible]

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BY: [Illegible]

FOR: [Illegible]

THROUGH: [Illegible]

BY: [Illegible]

626
50-10422

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10422

Registered No.

1. NAME OF DECEASED (Type or Print) MARTHA M. TROEGER			2. DATE OF DEATH Dec. 4, 1950		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE Md. B. COUNTY		
B. FULL NAME OF HOSPITAL OR INSTITUTION 1828 Bolton Street			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore		
C. Length of stay in Baltimore Yrs. Mos. Days			D. STREET ADDRESS (If rural, give location) 1828 Bolton Street		
5. SEX female	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) widowed	8. DATE OF BIRTH Jan. 8, 1889	9. AGE (In years last birthday) 61	If Under 1 Year Months: Days If Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife			11. BIRTHPLACE (State or foreign country) Maryland		
10B. KIND OF BUSINESS OR INDUSTRY at home			12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME Max E. Kunze			14. MOTHER'S MAIDEN NAME Johanna Englebrecht		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no		16. SOCIAL SECURITY NO. no	17. INFORMANT ADDRESS Mrs. Edith M. T. Conroy - 1828 Bolton St.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Carcinoma - Ovary DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Carcinoma left foot			INTERVAL BETWEEN ONSET AND DEATH 1 yr.		
19A. DATE OF OPERATION Nov. 19 49			19B. MAJOR FINDINGS OF OPERATION Carcinoma of Ovary - inoperable		
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21A. ACCIDENT WAS UNDER- Lying <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from 1938 , to Dec. 4 , 1950, that I last saw the deceased alive on Dec 25 , 1950 and that death occurred at 20 m., from the causes and on the date stated above.					
23A. SIGNATURE Sheldon Eastland			23B. ADDRESS Mrs. Edith M. T. Conroy, Baltimore Md		23C. DATE SIGNED 12/5/50
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial	24B. DATE 12/6/50	24C. NAME OF CEMETERY OR CREMATORY Druid Ridge Cem.		24D. LOCATION (City, town, or county) (State) Pikesville, Md.	
DATE RECEIVED BY LOCAL REGISTRAR DEC 5 - 1950		REGISTRAR'S SIGNATURE Wm. J. Pickner		25. FUNERAL DIRECTOR ADDRESS Wm. J. Pickner & Sons - Balt Md.	

35-11-1

STAFF - EX-10000

35-11-1

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325
50-10423BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50-10423

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

MATTIE V. WATKINS

2. DATE
OF
DEATH

12/15/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland ✓

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION

Church Home & Hospital

C. Length of stay in Baltimore

life

5. SEX

F.

6. COLOR OR RACE

White

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

Widowed

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

never worked

10B. KIND OF BUSINESS OR INDUSTRY

13. FATHER'S NAME

Philip Tilyard

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Md.

B. COUNTY

Baltimore

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Crown's Mills 5300

D. STREET ADDRESS (If rural, give location)

Helmwood Garrison Forest Rd.

8. DATE OF BIRTH

9/9/1866

9. AGE (In years last birthday)

84

If Under 1 Year Months: Days Hours: Min.

11. BIRTH PLACE (State or foreign country)

Md.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

14. MOTHER'S MAIDEN NAME

Anne Virginia Bauman

17. INFORMANT

ADDRESS

Church Home &

18. 450.0

CAUSE OF DEATH

INTERNAL BETWEEN UNSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11/12, 1950, to 12/15, 1950, that I last saw the deceased alive on 12/4, 1950, and that death occurred at 8:45 am, from the causes and on the date stated above.

23A. SIGNATURE

Dorance L. Lushberg

M. D.

23B. ADDRESS

Church Home & Hosp. 12/15/50

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

12/7/50

24C. NAME OF CEMETERY OR CREMATORY

St. Thomas Cem.

24D. LOCATION (City, town, or county)

Garrison Forest, Md.

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

DEC 5 - 1950

Wm. J. Williams, Jr.

25. FUNERAL DIRECTOR

ADDRESS

Wm. J. Dickner & Sons - Balto

520
50-10424

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10424

Registered No.

BIRTH NO. 30-26480

1. NAME OF DECEASED (Type or Print) Baby Boy Minogue			2. DATE OF DEATH 12/4/50		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Baltimore		
B. FULL NAME OF (If not in hospital or institution, give street address or location) St. Agnes Hospital			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Randalls town		
c. Length of stay in Baltimore			D. STREET ADDRESS (If rural, give location) Derby Rd. 5300		
5. SEX M	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH 12-2-50	9. AGE (In years last birthday) 0	10. Under 1 Year Months: Days Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Me.		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Joseph			14. MOTHER'S MAIDEN NAME Phyllis Beach		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO.	17. INFORMANT James Minogue - Sub. H. H. H.		

18. 768.5 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH Prematurely Meconium Peritonitis INTERVAL BETWEEN ONSET AND DEATH	(A) DUE TO	(B) DUE TO	(C) DUE TO
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			

19A. DATE OF OPERATION 12/3/50	19B. MAJOR FINDINGS OF OPERATION Meconium Peritonitis, Perforation colon at splenic flexure	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Splenic flexure
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED m. WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12/3/50 to 12/4/50, that I last saw the deceased alive on 12/4/50 and that death occurred at 3:15 P. M., from the causes and on the date stated above.

23A. SIGNATURE R. R. Ranner M. D. 23B. ADDRESS St. Agnes Hosp. 23C. DATE SIGNED 12/5/50

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial	24B. DATE 12-5-50	24C. NAME OF CEMETERY OR CREMATORY Woodlawn	24D. LOCATION (City, town, or county) (State) Baltimore, Md.
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DATE RECEIVED BY LOCAL REGISTRAR DEC 5 - 1950	REGISTRAR'S SIGNATURE W. J. Williams, M.D.	25. FUNERAL DIRECTOR George A. Jachy - Fulton & Fayette St.	ADDRESS
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MEDICAL CERTIFICATION

10-1-11

1/12

18-1-11

10-1-11

10-1-11

10-1-11

10-1-11

10-1-11

10-1-11

10-1-11

10-1-11

10-1-11

425

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10425

Registered No.

0-10425

1. NAME OF DECEASED (Type or Print) SAMUEL D. WILSON			2. DATE OF DEATH 12/5/50		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE PA B. COUNTY V-35		
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION 4024 DEERWOOD RD.			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) WILKINSBURG		
c. Length of stay in Baltimore Yrs. Mos. Days			D. STREET ADDRESS (If rural, give location) 825 WOODWORTH AVE		
5. SEX M	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED	8. DATE OF BIRTH JULY 24, 1861	9. AGE (in years, last birthday) 89	10. Under 1 Year Months: Days 11. Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CONTRACTING		10B. KIND OF BUSINESS OR INDUSTRY BUILDING	11. BIRTHPLACE (State or foreign country) PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME UNKNOWN			14. MOTHER'S MAIDEN NAME UNKNOWN		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS MR. JOHN W. DAVIS 4024 DEERWOOD RD.		

18. 331X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH
	(A) Cerebral Hemorrhage	DUE TO	2 yrs.
	(B) Generalized arteriosclerosis	DUE TO	20 yrs
	(C) Senility	DUE TO	20 yrs
		none	

19A. DATE OF OPERATION none		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) none		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) none		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) none	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY none		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? none	
22. I hereby certify that I attended the deceased from June , 19 49 , to Dec 5 , 19 50 , that I last saw the deceased alive on Nov 28 , 19 50 , and that death occurred at 1:00 p.m. , from the causes and on the date stated above.					
23A. SIGNATURE A.S. Chappin		23B. ADDRESS 6210 York Rd		23C. DATE SIGNED Dec 5, 50	
24A. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 12/8/50		24C. NAME OF CEMETERY OR CREMATORY MT ROYAL MAUSOLEUM	
				24D. LOCATION (City, town, or county) (State) GLENSHAW PA.	
DATE RECEIVED BY LOCAL REGISTRAR DEC 6 - 1950		REGISTRAR'S SIGNATURE William M. Williams		25. FUNERAL DIRECTOR ADDRESS JOHN F. DENNIS, INC. 715 LIGHT ST - 20	

MEDICAL CERTIFICATION

CSNCP-02

Dr A S Cleaffont
6210 York Rd

6 to 8:30 PM

620
50-10426BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10426

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

FRIEDDIE IANTHUS HARRIS

2. DATE
OF
DEATH

Dec. 4, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF
HOSPITAL OR
INSTITUTION (If not in hospital or institution, give street address or location)

US Marine Hospital

Wyman Pk. Drive & 31st St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE Ohio

B. COUNTY

before admission)

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Olmsted Falls

D. STREET ADDRESS (If rural, give location)

7622 Columbia Road

c. Length of stay in Baltimore

71 days

Yrs.
Mos.
Days

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Div.

8. DATE OF BIRTH

3/23/10

9. AGE (In years;
last birthday)

40

11 Under 1 Year
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Fireman

10B. KIND OF BUSINESS OR
INDUSTRY

Seafarer

11. BIRTHPLACE (State or foreign country)

Ohio

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Scott Alfred Harris

14. MOTHER'S MAIDEN NAME

Eva ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown)

?

(If yes, give war or dates of service)

16. SOCIAL
SECURITY NO.
271-10-8122

17. INFORMANT

ADDRESS

Records-US Marine Hospital, Balto, Md.

18. 193X

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) Glioblastoma multiforme

DUE TO

Unknown

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

9/27/50

19B. MAJOR FINDINGS OF OPERATION

Glioblastoma multiforme

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept. 24, 1950, to Dec. 4, 1950, that I last saw the deceased alive on Dec. 4, 1950, and that death occurred at 2:20 A. M., from the causes and on the date stated above.

23A. SIGNATURE

John L. Wilson, Medical Director

M. D.

23B. ADDRESS

US Marine Hospital, Balto, Md.

23C. DATE SIGNED

12/4/50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

12/6/50

24C. NAME OF CEMETERY OR CREMATORY

St Peter's Cemetery

24D. LOCATION (City, town, or county)

Baltimore - Maryland

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

DEC 6 - 1950

VS 150

68055 403-E-25th St. 54a

05247

550
50-10427

CERTIFICATE CORRECTED 12-11-50

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50-10427

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Benjamin Cammon			2. DATE OF DEATH Dec. 5, 1950		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE District of Columbia B. COUNTY V-48		
B. FULL NAME OF HOSPITAL OR INSTITUTION St. Joseph's Hospital			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Washington		
c. Length of stay in Baltimore			D. STREET ADDRESS (If rural, give location) 45 Fifty-Fourth Street		
5. SEX Male	6. COLOR OR RACE Colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH 1909 5-30-1906	9. AGE (In years, last birthday) 44 41	10. Under 1 Year Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Special Police			10B. KIND OF BUSINESS OR INDUSTRY Federal Gov.		
11. BIRTHPLACE (State or foreign country) Wash., D. C.			12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME Ben Cammon			14. MOTHER'S MAIDEN NAME Unknown		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes			16. SOCIAL SECURITY NO.		
17. INFORMANT Flora Cammon			ADDRESS 45-54th St SE.		

18. 151X I CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) Operative death due to shock

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Carcinoma of stomach with metastasis

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION Dec. 5, 1950		19B. MAJOR FINDINGS OF OPERATION Carcinoma of stomach with metastasis		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 12/2/1950, to 12/5/1950, that I last saw the deceased alive on 12/5/1950, and that death occurred at 11:25 AM, from the causes and on the date stated above.

23A. SIGNATURE William B. Reelgen	M. D.	23B. ADDRESS 1100 N. Caroline Street	23C. DATE SIGNED 12/5/50
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24A. BURIAL, CREMATION, REMOVAL (Specify) Burial	24B. DATE 12-8-50	24C. NAME OF CEMETERY OR CREMATORY Washington Williams, Md.	24D. LOCATION (City, town, or county) (State) Washington, D. C.
DATE RECEIVED BY LOCAL REGISTRAR DEC 6 - 1950		REGISTRAR'S SIGNATURE William Williams, Jr.	25. FUNERAL DIRECTOR Malvan & Schuy Inc.
		ADDRESS 424 R St. NW, D.C.	

CERTIFICATE OF DEATH

1. Name of Deceased		2. Sex		3. Age	
4. Date of Death		5. Time of Death		6. Place of Death	
7. Cause of Death		8. Manner of Death		9. Signature of Physician	
10. Signature of Registrar		11. Signature of Coroner		12. Signature of Medical Examiner	
13. Signature of Burial Officer		14. Signature of Undertaker		15. Signature of Cemetery	
16. Signature of Funeral Home		17. Signature of Family		18. Signature of Friends	
19. Signature of Neighbors		20. Signature of Community		21. Signature of Church	
22. Signature of School		23. Signature of Business		24. Signature of Government	
25. Signature of Other		26. Signature of Other		27. Signature of Other	
28. Signature of Other		29. Signature of Other		30. Signature of Other	
31. Signature of Other		32. Signature of Other		33. Signature of Other	
34. Signature of Other		35. Signature of Other		36. Signature of Other	
37. Signature of Other		38. Signature of Other		39. Signature of Other	
40. Signature of Other		41. Signature of Other		42. Signature of Other	
43. Signature of Other		44. Signature of Other		45. Signature of Other	
46. Signature of Other		47. Signature of Other		48. Signature of Other	
49. Signature of Other		50. Signature of Other		51. Signature of Other	
52. Signature of Other		53. Signature of Other		54. Signature of Other	
55. Signature of Other		56. Signature of Other		57. Signature of Other	
58. Signature of Other		59. Signature of Other		60. Signature of Other	
61. Signature of Other		62. Signature of Other		63. Signature of Other	
64. Signature of Other		65. Signature of Other		66. Signature of Other	
67. Signature of Other		68. Signature of Other		69. Signature of Other	
70. Signature of Other		71. Signature of Other		72. Signature of Other	
73. Signature of Other		74. Signature of Other		75. Signature of Other	
76. Signature of Other		77. Signature of Other		78. Signature of Other	
79. Signature of Other		80. Signature of Other		81. Signature of Other	
82. Signature of Other		83. Signature of Other		84. Signature of Other	
85. Signature of Other		86. Signature of Other		87. Signature of Other	
88. Signature of Other		89. Signature of Other		90. Signature of Other	
91. Signature of Other		92. Signature of Other		93. Signature of Other	
94. Signature of Other		95. Signature of Other		96. Signature of Other	
97. Signature of Other		98. Signature of Other		99. Signature of Other	
100. Signature of Other		101. Signature of Other		102. Signature of Other	

523

50-10428

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10428

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)JENNAN
Charles Kincaid Sr.2. DATE
OF
DEATH

Dec 2, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF
HOSPITAL OR
INSTITUTION

JOHNS HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

c. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

10-29-85

9. AGE (in years
last birthday)

65

10. Under 1 Year
Months: Days11. Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Supt. Highways - Dept.

10B. KIND OF BUSINESS OR
INDUSTRY

Balto. City

13. FATHER'S NAME

Frank Kincaid

11. PLACE OF BIRTH (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

USA

14. MOTHER'S MAIDEN NAME

Delphine Barr

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL
SECURITY NO.

17. INFORMANT ADDRESS

JOHNS HOPKINS HOSPITAL

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) ? Pulmonary Embolus

DUE TO

15 min

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) Carcinoma of Stomach
(C) ?

DUE TO

?

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

11/21/50

19B. MAJOR FINDINGS OF OPERATION

Carcinoma of Stomach

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11-14-1950 to 12-2-1950 that I last saw the
deceased alive on 12-2-1950 and that death occurred at 1:35 Pm., from the causes and on the date stated above.

23A. SIGNATURE

Charles M. Finn

M. D.

23B. ADDRESS

JOHNS HOPKINS HOSPITAL

23C. DATE SIGNED

12/2/50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

Dec 6-1950

24C. NAME OF CEMETERY OR CREMATORY

Norden Park Cem.

24D. LOCATION (City, town, or county)

Balto. Md.

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

DEC 6-1950

REGISTRAR'S SIGNATURE

Walter Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

H. B. Wipperfurth & Son 100 East Ave. Rd

VS 150

25093

46B 17

MEDICAL CERTIFICATION

[Faint, illegible text, likely bleed-through from the reverse side of the page]

455
50-10429

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50-10429

BIRTH NO.

1. NAME OF DECEASED (Type or Print) HERMAN MARTIN BELMAN		2. DATE OF DEATH 12-5-50	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE Where deceased lived. If institution: residence before admission) A. STATE Md B. COUNTY	
B. FULL NAME OF (If not in hospital or institution, give street address or location) Life		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore	
c. Length of stay in Baltimore		D. STREET ADDRESS (If rural, give location) 1540 No Broadway	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10B. KIND OF BUSINESS OR INDUSTRY Penn R R	9. AGE (in years last birthday) 45
11. FATHER'S NAME Harvey		12. CITIZEN OF WHAT COUNTRY?	
13. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		14. MOTHER'S MAIDEN NAME Rebecca	
15. SOCIAL SECURITY NO.		16. INFORMANT Viola Belman -	
17. ADDRESS		Same	

18. 420.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH. (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Pulmonary Edema	INTERVAL BETWEEN ONSET AND DEATH
CAUSE OF DEATH Coronary Heart Disease	
(A) DUE TO	
(B) DUE TO	
(C) DUE TO	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **2:45 AM 12-5-50**, to **4:05 AM 12-5-50**, that I last saw the deceased alive on **4-05 12-5-50**, and that death occurred at **4-05**, from the causes and on the date stated above.

23A. SIGNATURE William Brangel	23B. ADDRESS Kenai Hospital	23C. DATE SIGNED 12-5-50
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24A. BURIAL, CREMATION, REMOVAL (Specify) Burial	24B. DATE 12-7-50	24C. NAME OF CEMETERY OR CREMATORY Herring Run	24D. LOCATION (City, town, or county) (State) Balto Md
--	-----------------------------	--	--

DATE RECEIVED BY LOCAL REGISTRAR DEC 6 - 1950	REGISTRAR'S SIGNATURE William Brangel	25. FUNERAL DIRECTOR Jack Lewis	ADDRESS 2100 Belair Rd
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MEDICAL CERTIFICATION

24-10153

CENTRAL



200
50-10430BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50-10430
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Jean La Sou

2. DATE
OF DEATH 12-5-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR INSTITUTION

Susan

C. Length of stay in Baltimore

Life

Yrs.
Mos.
Days4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE

Md

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore 15-04

D. STREET ADDRESS (If rural, give location)

1830 W. North Ave

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Female

White

married

8. DATE OF BIRTH

9. AGE (In years, months, days)

10. Under 1 Year
Months: Days11. Under 24 Hours
Hours: Min.

38

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore Md

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Abraham Wexler

14. MOTHER'S MAIDEN NAME

Bertha

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Martin La Sou - Same

18. 416X

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

DUE TO

Cerebral embolism

INTERVAL BETWEEN ONSET AND DEATH

3 1/2 da.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

Aneurysm of brachial

chronic Rheumatic Ht. Dis.

(over)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from 12-2, 1950, to 12-5, 1950, that I last saw the deceased alive on 12-5, 1950 and that death occurred at 8:00 A.M., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

Ruth Blois

M. O.

Susan, 1803

12-5-50

24. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

DEC 6 - 1950

William Williams

Jack Lewis Inc 2100 Eastern Pl

1001 Was the rheumatic heart condition
accompanied by active rheumatic
fever at the time of death?

or inactive, quiescent - a chronic
condition?

"Chronic" - See Document File 50-10430
12/15/50 ES

620
50-10431BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50-10431

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <u>Joseph Grice</u>			2. DATE OF DEATH <u>12-3-50</u>		
3. PLACE OF DEATH: A. Baltimore City, Maryland <u>1502 Milliman St. BANC</u>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>		
B. FULL NAME OF HOSPITAL OR INSTITUTION <u>1502 Milliman St</u>			C. CITY OR TOWN (If outside corporate limits, with RURAL and give township) <u>Baltimore</u>		
D. STREET ADDRESS (If rural, give location) <u>804 Caroline St N.</u>			E. DATE OF BIRTH <u>8-12-1896</u>		
F. AGE (In years last birthday) <u>54</u>			G. Under 1 Year Months: Days: H. Under 24 Hours Hours: Min.		
I. SEX <u>M</u>			J. COLOR OR RACE <u>C</u>		
K. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>			L. BIRTHPLACE (State or foreign country) <u>Dillon S. Carolina</u>		
M. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dock Worker</u>			N. KIND OF BUSINESS OR INDUSTRY		
O. FATHER'S NAME <u>Joseph Grice</u>			P. MOTHER'S MAIDEN NAME <u>Frances Crawford</u>		
Q. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, do or unknown) (If yes, give war or dates of service) <u>No</u>			R. SOCIAL SECURITY NO.		
S. INFORMANT <u>Elijah Grice (son)</u>			T. ADDRESS <u>660 Sayford St Harrisburg Pa</u>		

18. 022X
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
CAUSE OF DEATH
(A) Luetic Cardiovascular Disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B) Aneurysm of Aorta
DUE TO
(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	

22. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE <u>William Vorwitz</u>		23B. CHIEF MEDICAL EXAMINER..... <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER..... <input checked="" type="checkbox"/> M.D. MEDICAL INVESTIGATOR		23C. DATE SIGNED <u>12-3-50</u>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12/7/50</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Mt. Cebrian</u>	
24D. LOCATION (City, town, or county) (State) <u>A. C. County. Md</u>					

DATE RECEIVED BY LOCAL REGISTRAR DEC 6 - 1950 REGISTRAR'S SIGNATURE William Vorwitz FUNERAL DIRECTOR Joseph B. Lock, Jr. ADDRESS 304 N. Central Ave

10101-00

U.S. DEPARTMENT OF THE INTERIOR

BUREAU OF LAND MANAGEMENT

10101-00



620
50-10432

HARRIS
BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10432
Registered No.

BIRTH NO. 50-10432		1. NAME OF DECEASED (Type or Print) <i>Baby Boy Harris</i>		2. DATE OF DEATH <i>11-29-50</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <i>Balto. Md.</i>		4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission) A. STATE <i>MD.</i> B. COUNTY <i>MD.</i>			
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>University Hospital</i>		C. CITY OR TOWN (If outside corporate limits, write R.U.C.A. and give township) <i>Baltimore</i>			
c. Length of stay in Baltimore <i>5</i> Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) <i>541 S. Para. St.</i>			
5. SEX <i>M</i>	6. COLOR OR RACE <i>C</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>S</i>	8. DATE OF BIRTH <i>11-23-50</i>	9. AGE (In years last birthday) <i>56</i>	10. Under 1 Year Months: Days 11. Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>MD.</i>	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <i>Thomas Taylor</i>		14. MOTHER'S MAIDEN NAME <i>Odeessa Harris</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <i>Odeessa Harris</i>	
18. <i>776x</i> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH <i>Prematurely</i> DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (B) (C) OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION <i>0</i>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE <input type="checkbox"/> AT WORK		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>11-23</i> , 19 <i>50</i> , <i>11-29</i> , 19 <i>50</i> , that I last saw the deceased alive on <i>11-29</i> , 19 <i>50</i> , and that death occurred at <i>4:10 Pm.</i> , from the causes and on the date stated above.					
23A. SIGNATURE <i>Robert M. Hiley</i>		23B. ADDRESS <i>University Hospital</i>		23C. DATE SIGNED <i>11-29-50</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY <i>UNIVERSITY MEDICAL SCHOOL</i>	
24D. LOCATION (City, town, or county)		24E. FUNERAL DIRECTOR <i>Commissioner of Health</i>		24F. ADDRESS	

3-10-1952

RECEIVED
OFFICE OF THE
DIRECTOR OF THE
BUREAU OF THE
CENSUS

7



650
50-10433

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10433

Registered No.

1. NAME OF DECEASED (Type or Print) Eva Baron		2. DATE OF DEATH December 5, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 27-17	
B. FULL NAME OF HOSPITAL OR INSTITUTION 4913 Chalgrove Ave		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore	
c. Length of stay in Baltimore 38 yrs Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) 4913 Chalgrove Ave	
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) WIDOW	8. DATE OF BIRTH May 15, 1895
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		9. AGE (In years last birthday) 55	11. BIRTHPLACE (State or foreign country) Lith
10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Nathan Lurie		14. MOTHER'S MAIDEN NAME Ida ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs Betty Baer		ADDRESS 4915 Chalgrove Ave	
18. 420.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) Cosmancy occlusion DUE TO Posterior infection. (B) _____ DUE TO _____ (C) _____ INTERVAL BETWEEN ONSET AND DEATH Hidden Dec 1, 1950			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION 0		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDER- Lying <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from July Dec 1, 1950 , to Dec 5, 1950 , that I last saw the deceased alive on Dec 5, 1950 , and that death occurred at 2:10 P. M. , from the causes and on the date stated above.			
23A. SIGNATURE William E. Lorman		23B. ADDRESS 4843 Park Heights Ave	
23C. DATE SIGNED 12-5-50			
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE Dec 6, 1950	
24C. NAME OF CEMETERY OR CREMATORY Hebrew Herring Run Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore Md	
DATE RECEIVED BY LOCAL REGISTRAR DEC 6 - 1950		REGISTRAR'S SIGNATURE William E. Lorman	
25. FUNERAL DIRECTOR Sam L. Lorman & Sons		ADDRESS 1126 W North Ave	

100-100

100-100



**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

50-10434
Registered No. 50-10434

BIRTH NO. 50-10434

Belinda

1. NAME OF DECEASED
(Type or Print)

Belinda Lucy Green

2. DATE
OF
DEATH

12/5/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION

Windsor Court Apts

Length of stay in Baltimore

76 Yrs.
Mos.
Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

Windsor Ct Apts - 2425 Remond Blvd

5. SEX

F

6. COLOR OR RACE

W

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)
Single

8. DATE OF BIRTH

Nov. 19, 1870

9. AGE (In years last birthday)

80

10. Under 1 Year
Months: Days

11. Under 24 Hours
Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

None

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Randallsburg, Ohio

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

William H. Green

14. MOTHER'S MAIDEN NAME

Julia Barron Ware

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Harry B. Haley 3408 Old York Road

CAUSE OF DEATH

18. *42001*

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) *Ante-mortem C.V. disease*

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

INTERVAL BETWEEN
ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS
PRIMARY ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED
WHILE AT ☐ NOT WHILE
WORK ☐ AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an *Inspected* thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

P. D. Sullivan

23B. CHIEF MEDICAL EXAMINER.....
ASSISTANT MEDICAL EXAMINER.....
MEDICAL INVESTIGATOR.....

23C. DATE SIGNED
12/5/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

12/7/50

24C. NAME OF CEMETERY OR CREMATORY

Prospect Hill

24D. LOCATION (City, town, or county)

Towson, Md.

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Washington Williams

25. FUNERAL DIRECTOR

ADDRESS

W. W. Meade, Jr. 505 N. Calvert

DEC 6 - 1950

CERTIFICATE OF DEATH

State of New York

County of _____

City of _____

On this _____ day of _____

19____

at _____

**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

50-10435

Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED (Type or Print) FELIX ZALESKI			2. DATE OF DEATH 12-7-50		
3. PLACE OF DEATH: A. Baltimore City, Maryland BALTO.			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE BALTO B. COUNTY BALTO C. CITY OR TOWN BALTO D. STREET ADDRESS (If rural, give location) 1117 HULL ST.		
B. FULL NAME OF (If not in hospital or institution, give street address or location) 1117 HULL ST.			E. STREET ADDRESS (If rural, give location) 1117 HULL ST.		
c. Length of stay in Baltimore 40			5. SEX M. 6. COLOR OR RACE W. 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LONG SHORE MAN			10B. KIND OF BUSINESS OR INDUSTRY		
13. FATHER'S NAME UNKNOWN			11. BIRTHPLACE (State or foreign country) Poland		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)			12. CITIZEN OF WHAT COUNTRY?		
16. SOCIAL SECURITY NO. 2-16-09-3373			14. MOTHER'S MAIDEN NAME Unknown		
17. INFORMANT			ADDRESS		

18. 561.0 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Incarcerated Inguinal Hernia Shock Absorption of Toxins Cessation of heart function		INTERVAL BETWEEN ONSET AND DEATH 2 days 2 days 0
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION 0		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Dec. 2, 19 50 , to Dec. 3, 19 50 , that I last saw the deceased alive on Dec. 2, 19 50 , and that death occurred at 11:40 P. , from the causes and on the date stated above.					
23A. SIGNATURE William J. Miller		23B. ADDRESS 516 Cathedral St.		23C. DATE SIGNED 12/5/50	
24A. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 12-7-50		24C. NAME OF CEMETERY OR CREMATORY Holy Cross A. A. Co.	
24D. LOCATION (City, town, or county) (State) A. A. Co. Md.		25. FUNERAL DIRECTOR Charles F. Dill		ADDRESS 1501 E. Fort Ave	

CONFIDENTIAL

MEMORANDUM FOR THE DIRECTOR

100-100000

TO : DIRECTOR, FBI
FROM : SAC, NEW YORK
SUBJECT: [Illegible]

RE: [Illegible]
[Illegible text block]

1. [Illegible]
2. [Illegible]
3. [Illegible]

4. [Illegible]
5. [Illegible]
6. [Illegible]

7. [Illegible]
8. [Illegible]
9. [Illegible]
10. [Illegible]

235
50-10436

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10436

Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED (Type or Print) <u>Patrick J. McDonnell</u>		2. DATE OF DEATH <u>Dec. 4, 1950</u>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <u>1008 Forest St</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY _____	
B. FULL NAME OF HOSPITAL OR INSTITUTION _____		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <u>Baltimore 10-01</u>	
D. STREET ADDRESS (If rural, give location) <u>1008 Forest St.</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>	
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>single</u>		8. DATE OF BIRTH <u>Aug 1873</u>	
9. AGE (in years: last birthday) <u>77</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Pulper</u>	
11. BIRTHPLACE (State or foreign country) <u>Ireland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Patrick McDonnell</u>		14. MOTHER'S MAIDEN NAME <u>Mary</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) _____		16. SOCIAL SECURITY NO. <u>215-09-4543</u>	
17. INFORMANT <u>Mary McDonnell</u>		ADDRESS <u>1008 Forest St.</u>	

18. <u>470.1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>Coronary Thrombosis</u> DUE TO <u>Arteriosclerotic Disease</u> DUE TO <u>?</u>		INTERVAL BETWEEN ONSET AND DEATH <u>9 days</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION <u>0</u>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) _____		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY _____		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? _____	
22. I hereby certify that I attended the deceased from <u>15 Nov</u> , 19 <u>50</u> , to <u>4 Dec</u> , 19 <u>50</u> , that I last saw the deceased alive on <u>2 Dec</u> , 19 <u>50</u> , and that death occurred at <u>11:55 A.M.</u> , from the causes and on the date stated above.					
23A. SIGNATURE <u>Samuel Scherfer</u>		23B. ADDRESS <u>714 E. Preston St</u>		23C. DATE SIGNED <u>4 Dec 1950</u>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE _____		24C. NAME OF CEMETERY OR CREMATORY <u>Cathedral</u>	
24D. LOCATION (City, town, or county) <u>Baltimore</u>		24E. STATE _____		24F. FUNERAL DIRECTOR <u>Wm. W. Redfield</u>	
24G. ADDRESS <u>900 E. Biddle St.</u>		24H. DATE RECEIVED BY LOCAL REGISTRAR <u>DEC 6 - 1950</u>		24I. REGISTRAR'S SIGNATURE <u>Wm. J. Williams, M.D.</u>	

MEDICAL CERTIFICATION

565
50-10437BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10437

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

WILLIAM O. ZIMMERMAN

2. DATE
OF
DEATH

12-5-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION

Sinai Hospital

Yrs.
Mos.
Days

C. Length of stay in Baltimore

4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)
A. STATE

Md.

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township)

Baltimore,

D. STREET ADDRESS (If rural, give location)

3102 Spaulding Ave.

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

Aug. 14, 1881

9. AGE (In years
last birthday)

67

10. Under 1 Year
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Ret. Stationary Engineer,

10B. KIND OF BUSINESS OR
INDUSTRY

Dairy

11. BIRTHPLACE (State or foreign country)

Baltimore County, Md.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Julius E. Zimmerman,

14. MOTHER'S MAIDEN NAME

Catherine Greenwalt.

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

216-10-8709

17. INFORMANT

ADDRESS

Mrs. S. A. Zimmerman, 3102 Spaulding Ave.

18. 451 X I

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

CAUSE OF DEATH

(A)

DUE TO

(B)

DUE TO

(C)

Retroperitoneal Hemorrhage

Ruptured aortic aneurysm
(Origin probably arteriosclerotic)INTERVAL BETWEEN
ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12-4 1950 to 12-5, 1950 that I last saw the
deceased alive on 12-5, 1950, and that death occurred at 4:45 A. M., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

M. D.

12-5-50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

burial

24B. DATE

12/7/50

24C. NAME OF CEMETERY OR CREMATORY

Woodlawn,

24D. LOCATION (City, town, or county) (State)

Woodlawn, Balto. Co. Md.

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

DEC 6 - 1950

W. H. Williams, Jr.

Vernon Lamm, 4611 Park Heights Ave.

was the aortic aneurysm
hypertensive or arteriosclerotic
in origin?

See Document File 50-10437
12/13/50 ES

155
50-10438BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10438

Registered No.

1. NAME OF DECEASED (Type or Print) <i>Charles R. Hoffman Sr.</i>		2. DATE OF DEATH <i>12/5/50</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>1208 W. Pratt St.</i>		C. CITY OR TOWN (If outside incorporated limits, state RURAL and give township) <i>Baltimore</i>	
C. Length of stay in Baltimore <i>50 yrs</i>		D. STREET ADDRESS (If rural, give location) <i>1208 W. Pratt St.</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>married</i>	8. DATE OF BIRTH <i>1/8/1867</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>carpenter</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>for self</i>	9. AGE (In years last birthday) <i>83</i>
11. BIRTHPLACE (State or foreign country) <i>Frederick Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Unknown</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Louise R. Hoffman</i>		ADDRESS <i>1208 W. Pratt St.</i>	

18. <i>331X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	CAUSE OF DEATH (A) <i>Cerebral Hemorrhage</i> DUE TO (B) <i>Hypertension</i> DUE TO (C) <i>Bronchopneumonia</i>	INTERVAL BETWEEN ONSET AND DEATH
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from *Jan 13, 1947* to *Dec. 5, 1950* that I last saw the deceased alive on *Dec 5, 1950* and that death occurred at *3:30* m., from the causes and on the date stated above.

23A. SIGNATURE <i>William H. Williams</i>	23B. ADDRESS <i>1429 W. Fayette St.</i>	23C. DATE SIGNED <i>12/16/50</i>
--	--	-------------------------------------

24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>12/8/50</i>	24C. NAME OF CEMETERY OR CREMATORY <i>Mt. Olivet Cem.</i>	24D. LOCATION (City, town, or county) (State) <i>2930 Frederick Ave</i>
DATE RECEIVED BY LOCAL REGISTRAR <i>DEC 6 - 1950</i>	REGISTRAR'S SIGNATURE <i>William H. Williams</i>	25. FUNERAL DIRECTOR <i>John J. Lowan & Son</i>	
		ADDRESS <i>83a St.</i>	

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STON-10-10-10

261
50-10439BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10439

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Anna L. Cosgrove

2. DATE
OF
DEATH

12/4/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF
HOSPITAL OR
INSTITUTION

1328 McHenry St.

C. Length of stay in Baltimore

60 yrs

Yrs.
Mos.
Days

5. SEX

Female

6. COLOR OR RACE

white

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

Widowed

10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

House work at home

10B. KIND OF BUSINESS OR
INDUSTRY

13. FATHER'S NAME

Michael J. Gannon

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL
SECURITY NO.

8. DATE OF BIRTH

11/12/1870

9. AGE in years
last birthday

88

11 Under 1 Year
Months: Days12 Under 24 Hours
Hours: Min.

11. BIRTHPLACE (State or foreign country)

Ireland

12. CITIZEN OF
WHAT COUNTRY?

USA

14. MOTHER'S MAIDEN NAME

Ellen Nester

17. INFORMANT

ADDRESS

Mrs Catherine Troeb Woodruff St.

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A)

DUE TO

Hypostatic Pneumonia

3 days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

Enforced Bed rest, Chronic C.V. disease Years

(C)

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

Ununited fracture of left femur 1 year

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH21B. PLACE OF INJURY (e.g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July, 1950 to Dec. 4, 1950, that I last saw the
deceased alive on Dec 4, 1950, and that death occurred at 13 p.m., from the causes and on the date stated above.

23A. SIGNATURE

Abram Goldman M.D.

23B. ADDRESS

206 S. Gilman St.

23C. DATE SIGNED

12/5/50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

12/7/50

24C. NAME OF CEMETERY OR CREMATORY

St Peter's Cem.

24D. LOCATION (City, town, or county)

Moreland Ave

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

William Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

John J. Cowan & Son Hollis

VS 150

93D

0111-10

021

5-10-10

[Faint, illegible handwriting on lined paper]

630
50-10440-49-02768BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10440

Registered No.

1. NAME OF DECEASED (Type or Print) NANCY HURTT			2. DATE OF DEATH December 4, 1950		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY		
B. FULL NAME OF HOSPITAL OR INSTITUTION 1625 Spruce Street			C. CITY OR TOWN (If outside corporate limits, write "RURAL" and give township) Baltimore		
C. Length of stay in Baltimore			D. STREET ADDRESS (If rural, give location) 1625 Spruce St.		
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH Feb. 10, 1949		9. AGE (In years last birthday) 21
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY ✓
13. FATHER'S NAME Jack Charles Hurtt			14. MOTHER'S MAIDEN NAME Helen Beatrice Halbrok		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT Jack Charles Hurtt ADDRESS 1625 Spruce St.		

18. 491X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Bronchopneumonia DUE TO (A) Antecedent Causes (B) Diseases or Conditions, if any, giving rise to the above cause (A) stating the underlying condition last. (C) II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	INTERVAL BETWEEN ONSET AND DEATH
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19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	

22. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE <i>William W. Denny</i>		23B. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> MEDICAL INVESTIGATOR <input type="checkbox"/>		23C. DATE SIGNED Dec. 4, 1950	
24A. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 12/7/50		24C. NAME OF CEMETERY OR CREMATORY LODON PARK CEM.	
24D. LOCATION (City, town, or county) (State) BALTO., MD.					

DATE RECEIVED BY LOCAL REGISTRAR DEC 6 - 1950		REGISTRAR'S SIGNATURE <i>William W. Denny</i>		25. FUNERAL DIRECTOR JOHN F. DENNY, INC ADDRESS 715 LIGHT ST.	
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1875

12/5/51

James H. Brown

ON 10/11/19

John F. Bony, Jr. 1882

625
50-10441

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10441

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Mr. Thomas Jefferson Morgan

2. DATE
OF
DEATH

Dec. 5, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

St. Joseph's Hospital

C. Length of stay in Baltimore

Yrs.
Mos.
Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

4400 Grandview Avenue

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Feb 20, 1868

9. AGE (In years last birthday)

82

10. Under 1 Year Months: Days

11. Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Retired Builder

10B. KIND OF BUSINESS OR INDUSTRY

Munsey Bldg Co

11. BIRTHPLACE (State or foreign country)

Baltimore Co., Md.

12. CITIZEN OF WHAT COUNTRY?

U.S.

13. FATHER'S NAME

John T. Morgan

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

14. MOTHER'S MAIDEN NAME

Ellen Fife

17. INFORMANT

ADDRESS

Anna E. Morgan, 4400 Grandview Ave

18. 578X

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Gastrointestinal hemorrhage, etiology undetermined

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

II

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11/24/1950 to 12/5/1950 that I last saw the deceased alive on 12/5/1950, and that death occurred at 1:45 P.M. from the causes and on the date stated above.

23A. SIGNATURE

John Joseph Krejci

M. D.

23B. ADDRESS

1400 N. Caroline Street

23C. DATE SIGNED

12/5/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

Woodlawn

Woodlawn

Woodlawn, Md

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

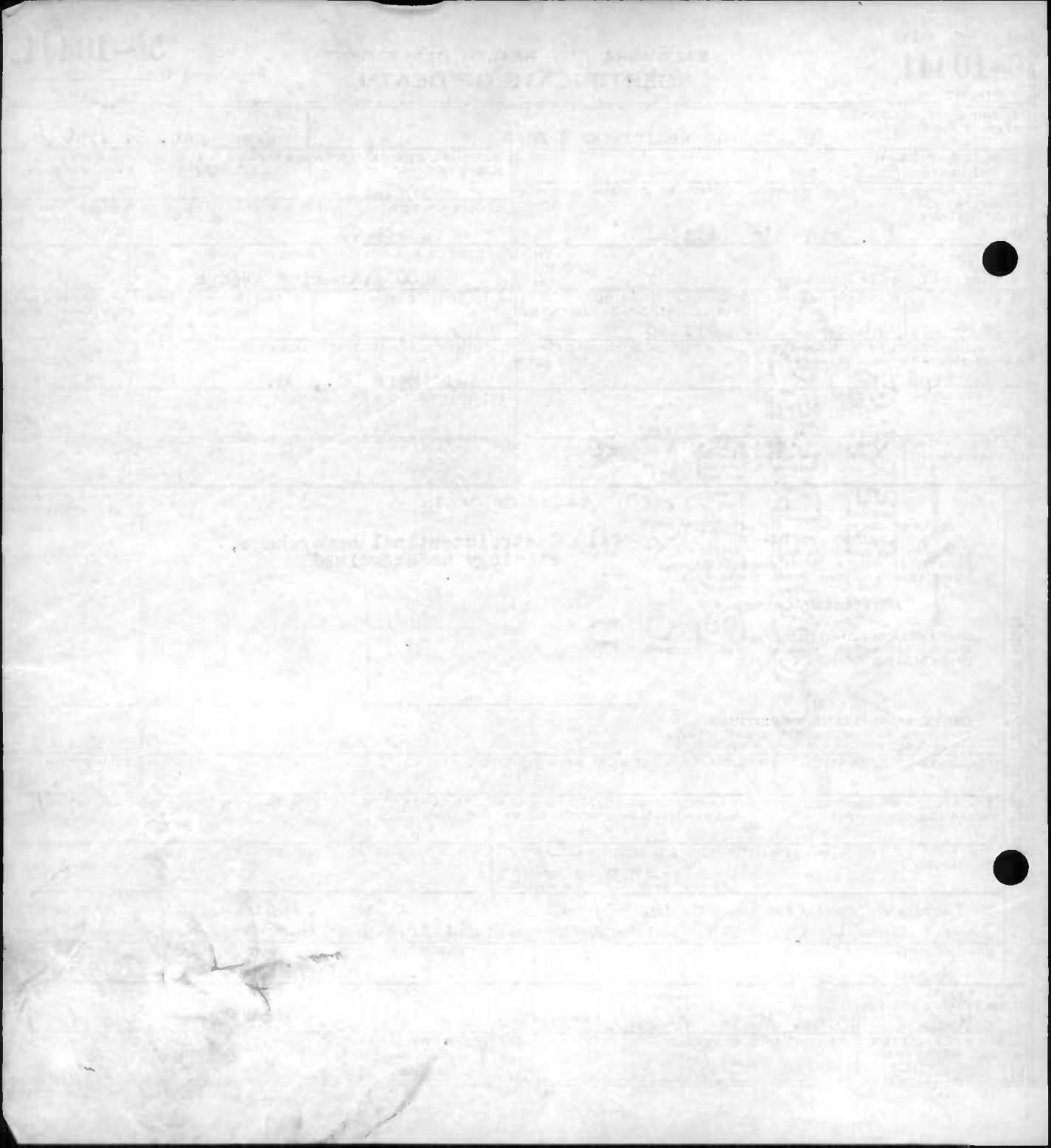
25. FUNERAL DIRECTOR

ADDRESS

DEC 6 - 1950

William M. Williams

Justin E. Donovan 3815 Poland Ave



**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

50-10442

Registered No. _____

BIRTH NO. 50-05131

1. NAME OF DECEASED (Type or Print) <u>LEO KROUT</u>			2. DATE OF DEATH <u>December 5, 1950</u>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY _____		
B. FULL NAME OF (If not in hospital or institution, give street address or location) <u>2644 Hampden Avenue</u>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <u>Baltimore</u>		
C. Length of stay in Baltimore Yrs. _____ Mos. _____ Days _____			D. STREET ADDRESS (If rural, give location) <u>2644 Hampden Avenue</u>		
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>SINGLE</u>	8. DATE OF BIRTH <u>MARCH 13, 1950</u>		9. AGE (In years last birthday) <u>8</u> If Under 1 Year: Months: <u>13</u> Days: _____ If Under 24 Hours: Hours: _____ Min: _____
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10B. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			13. FATHER'S NAME <u>WALLACE KROUT</u>		
14. MOTHER'S MAIDEN NAME <u>ALICE WHITE</u>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) _____		
16. SOCIAL SECURITY NO. _____			17. INFORMANT ADDRESS <u>WALLACE KROUT - 2644 HAMPDEN AVE</u>		

18. <u>3403</u> CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Purulent bilateral otitis media</u>		
ANTECEDENT CAUSES <u>Purulent meningitis</u>		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <u>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</u>		

19A. DATE OF OPERATION <u>7</u>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		

22. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE <u>Stanley H. Dunleaver</u>	23B. CHIEF MEDICAL EXAMINER..... <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER..... <input checked="" type="checkbox"/> MEDICAL INVESTIGATOR..... <input type="checkbox"/>	23C. DATE SIGNED <u>Dec. 6, 1950</u>
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24A. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>Dec 7/50</u>	24C. NAME OF CEMETERY OR CREMATORY <u>New Cathedral</u>	24D. LOCATION (City, town, or county) (State) <u>Old Frederick Rd Md</u>
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DATE RECEIVED BY LOCAL REGISTRAR <u>DEC 6 - 1950</u>	REGISTRAR'S SIGNATURE <u>Washington Williams, Jr.</u>	25. FUNERAL DIRECTOR <u>Austin E. Donovan - 3818 Roland</u>	ADDRESS <u>89a</u>
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SI 101-102

STANDARD FORM NO. 64 (REV. 1-1957)

101-102

STANDARD FORM NO. 64

SI 101-102

STANDARD FORM NO. 64

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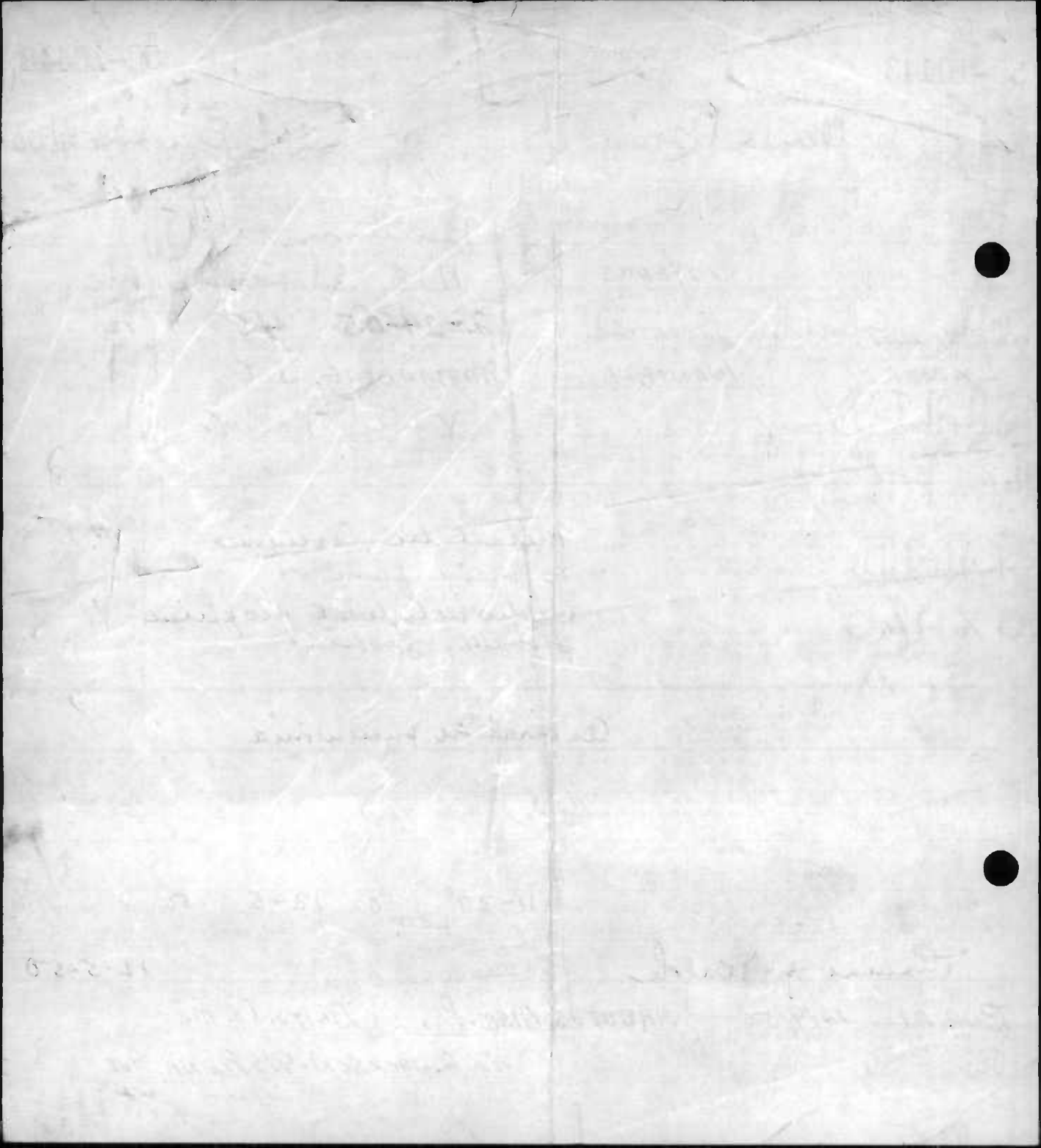
GRAY

50-10443

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50-10443

1. NAME OF DECEASED (Type or Print) <i>William Gray</i>		2. DATE OF DEATH <i>December 5, 1950</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>md.</i> B. COUNTY <i>16-01</i>	
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>THE JOHNS HOPKINS HOSPITAL</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore</i>	
C. Length of stay in Baltimore <i>17 YEARS</i>		D. STREET ADDRESS (If rural, give location) <i>1108 Edmondson Ave.</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>Colored</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>married</i>	8. DATE OF BIRTH <i>2-24-05</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>LABORER</i>	10B. KIND OF BUSINESS OR INDUSTRY <i>INDUSTRIAL GENERAL</i>	9. AGE (In years last birthday) <i>45</i>	11. BIRTHPLACE (State or foreign country) <i>SPARTANBURG, S.C.</i>
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <i>John Gray</i>	
14. MOTHER'S MAIDEN NAME <i>Viola Kelly</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT <i>THE JOHNS HOPKINS HOSPITAL</i>	
18. <i>151X</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Metastatic Carcinoma to brain from Gastric intestinal neoplasm probably gastric.</i>		INTERVAL BETWEEN ONSET AND DEATH <i>?</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Aspiratory pneumonia</i>	
19A. DATE OF OPERATION <i>0</i>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH	
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I hereby certify that I attended the deceased from <i>11-27</i> , 1950, to <i>12-5</i> , 1950, that I last saw the deceased alive on <i>12-5</i> , 1950, and that death occurred at <i>4:27 P.M.</i> , from the causes and on the date stated above.	
23A. SIGNATURE <i>Thomas J. Walsh</i>		23B. ADDRESS <i>THE JOHNS HOPKINS HOSPITAL</i>	
23C. DATE SIGNED <i>12-5-50</i>		24A. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	
24B. DATE <i>12/9/50</i>		24C. NAME OF CEMETERY OR CREMATORY <i>ARBUTUS MEM. PK.</i>	
24D. LOCATION (City, town, or county) (State) <i>BALTO. CO. MD</i>		25. FUNERAL DIRECTOR <i>Wm. A. JACKSON-916 PENNA. AVE</i>	
DATE RECEIVED BY LOCAL REGISTRAR <i>DEC 6 - 1950</i>		REGISTRAR'S SIGNATURE <i>William A. Jackson</i>	



615
-10444BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50-10444

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

ANTHONY Grabonawich

URBONAS

2. DATE

OF DEATH December 5, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

University Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

665 Portland Street

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

widowed

8. DATE OF BIRTH

Aug. 23-1878

9. AGE (In years last birthday)

72

10 Under 1 Year Months: Days

11 Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Stockier

10B. KIND OF BUSINESS OR INDUSTRY

Bethlehem Steel Co

11. BIRTHPLACE (State or foreign country)

Lettinawice

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

216-70-465

17. INFORMANT

ADDRESS

Stephen Urbonas 665 Portland

18. E9000

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Fractured skull

DUE TO

ANTECEDENT CAUSES

(B) Arteriosclerotic cardiovascular disease

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

Home

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

665 Portland Street

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

December 5, 1950 8.15 Am.

21E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR?

Fell down area way steps at his home

22. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

Stanley K. Durlacher M.D.

23B. CHIEF MEDICAL EXAMINER.....
ASSISTANT MEDICAL EXAMINER.....
MEDICAL INVESTIGATOR.....

23C. DATE SIGNED

12-5-50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

12-9-50

24C. NAME OF CEMETERY OR CREMATORY

Holy Redeemer

24D. LOCATION (City, town, or county)

Baltimore Md

(State)

DATE RECEIVED BY LOCAL REGISTRAR

DEC 6-1950

REGISTRAR'S SIGNATURE

Anthony W. Williams

25. FUNERAL DIRECTOR

Chas W. Fackhaus 703 McKury

ADDRESS

VS 151

N-803.2

970-3A

186a

MEDICAL CERTIFICATION

Grabonawic

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. **50-10445**

525
50-10445

BIRTH NO.

1. NAME OF DECEASED (Type or Print) MYRTLE MARIE FINACOM			2. DATE OF DEATH Dec 5, 1950		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY		
B. FULL NAME OF HOSPITAL OR INSTITUTION 311 East Twenty Fourth St			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore City		
C. Length of stay in Baltimore 17 yrs			D. STREET ADDRESS (If rural, give location) 311 East 24th Street		
5. SEX Female	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH Jan 21, 1897		9. AGE (In years last birthday) 53
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) house work		10B. KIND OF BUSINESS OR INDUSTRY own home	11. BIRTHPLACE (State or foreign country) Unknown		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no		16. SOCIAL SECURITY NO. None		17. INFORMANT George Finacom	
				ADDRESS 311 E. 24th St	

18. 4201 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Coronary Thrombosis		INTERVAL BETWEEN ONSET AND DEATH 24 hrs
DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Arteriosclerotic Coronary Artery Disease 5 yrs		
DUE TO Arterial Hypertension		7 yrs
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION None		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from **Sept 11, 1933**, to **Dec 5, 1950**, that I last saw the deceased alive on **Nov 29, 1950**, and that death occurred at **1 A** m., from the causes and on the date stated above.

23A. SIGNATURE **Joshua H. Ammerst** M. O. **6419 Windsor Mill Rd** 23B. ADDRESS
23C. DATE SIGNED **Dec 5, 1950**

24A. BURIAL, CREMATION, REMOVAL (Specify) **Burial** 24B. DATE **12/8/50** 24C. NAME OF CEMETERY OR CREMATORY **Catto. Mat'l. Cem.** 24D. LOCATION (City, town, or county) (State) **Catto. Md.**

DATE RECEIVED BY LOCAL REGISTRAR REGISTRAR'S SIGNATURE **William** 25. FUNERAL DIRECTOR **Wm. J. Tichenor** ADDRESS **94a Md.**

DECE-1950

VS 150

MEDICAL CERTIFICATION

CENTRAL INTELLIGENCE AGENCY

REPORTING OFFICER: MARIE J. JOHNSON

Subject: [Illegible]
Date: [Illegible]
Location: [Illegible]
[The remainder of the page contains several paragraphs of extremely faint, illegible text, likely a report or memorandum.]

536
0-10446

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10446

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) JOHN SCOTT HUNTER		2. DATE OF DEATH Dec. 4, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 12	
B. FULL NAME OF (If not in hospital or institution, give street address or location) Hopkins Apts. - 3100 St. Paul St.		C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township) Baltimore	
c. Length of stay in Baltimore Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) 3100 St. Paul St.	
5. SEX male	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH Mar. 23, 1886
9. AGE (In years last birthday) 64		10. UNDER 1 Year Months: Days 11. UNDER 24 Hours Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant		10B. KIND OF BUSINESS OR INDUSTRY Building Supplies	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME OWNER John Hunter		14. MOTHER'S MAIDEN NAME Lottie Albaugh	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) -		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Pearl Mullican Hunter-3100 St. Paul		ADDRESS St.	

18. 331X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Cerebral Hemorrhage DUE TO Arteriosclerosis DUE TO Anterior DUE TO Arteriosclerosis DUE TO Arteriosclerosis	CAUSE OF DEATH Cerebral Hemorrhage DUE TO Arteriosclerosis DUE TO Anterior DUE TO Arteriosclerosis DUE TO Arteriosclerosis	INTERVAL BETWEEN ONSET AND DEATH 12 Hrs.
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION 0	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **Dec 1**, 1950, to **Dec 4**, 1950, that I last saw the deceased alive on **Dec 4**, 1950, and that death occurred at **8:10 PM**, from the causes and on the date stated above.

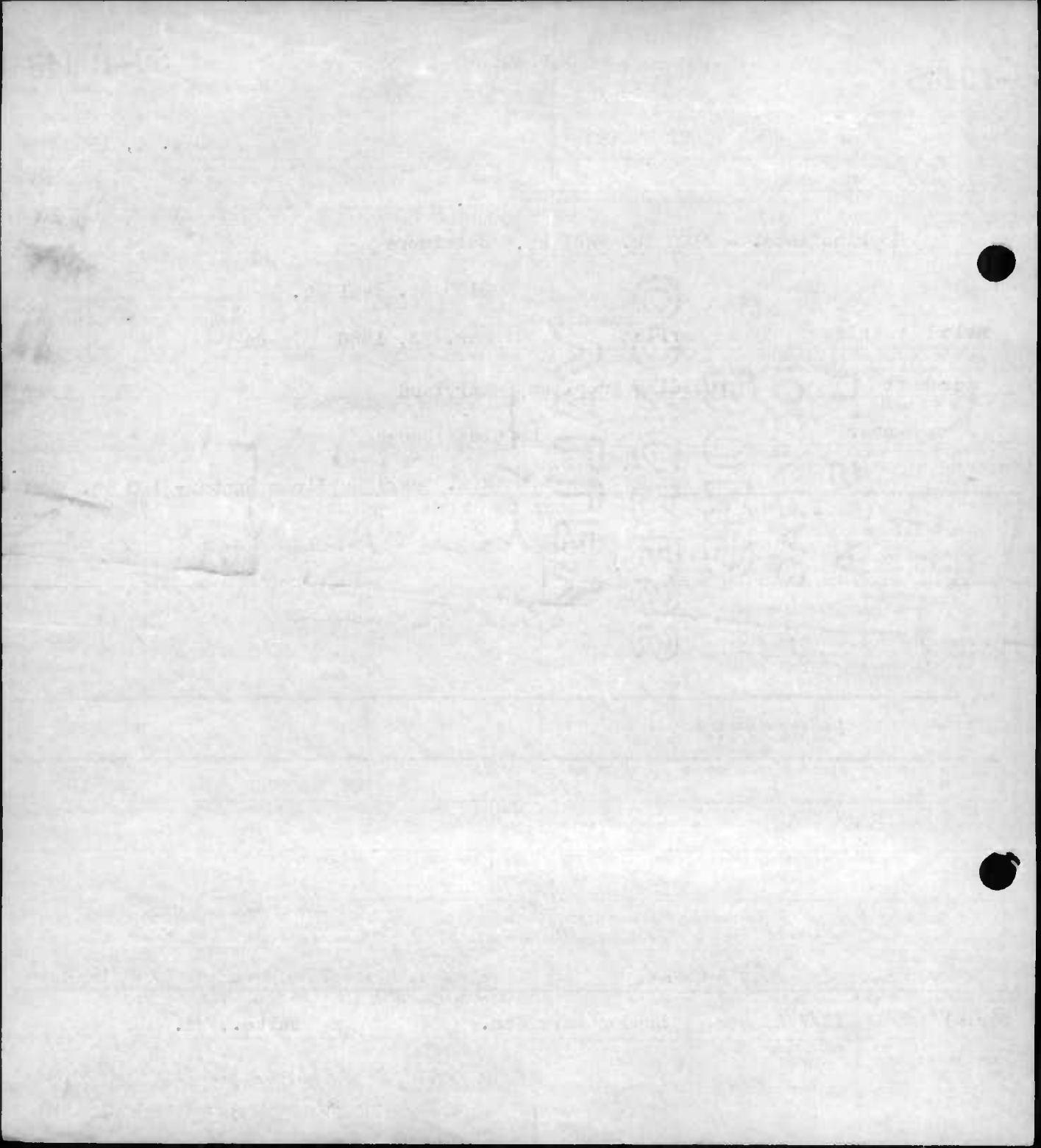
23A. SIGNATURE Henry C. Hancock	23B. ADDRESS 1929 44th St. E. S.E.	23C. DATE SIGNED 12/6/50
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24A. BURIAL, CREMATION, REMOVAL (Specify) Burial	24B. DATE 12/7/50	24C. NAME OF CEMETERY OR CREMATORY Loudon Park Cem.	24D. LOCATION (City, town, or county) (State) Balto., Md.
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DATE RECEIVED BY LOCAL REGISTRAR DEC 6 - 1950	REGISTRAR'S SIGNATURE William J. Lickens	25. FUNERAL DIRECTOR William J. Lickens	ADDRESS Balto., Md.
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29068

83a



100
50-10447

CERTIFICATE CORRECTED

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 50-10447

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

STERLING HUFF

2. DATE

OF DEATH December 5, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR INSTITUTION

Johns Hopkins Hospital

C. Length of stay in Baltimore

Yrs.
Mos.
Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore

D. STREET ADDRESS (If rural, give location)

1215 E. Oliver Street 1018 Latrobe St.

5. SEX

male

6. COLOR OR RACE

colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

married

8. DATE OF BIRTH

10/1/17

9. AGE (In years last birthday)

33

If Under 1 Year Months: Days

If Under 24 Hours Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Unemployed Laborer

10B. KIND OF BUSINESS OR INDUSTRY

Eastern Contractors

11. BIRTHPLACE (State or foreign country)

Jacksonville Fla.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Unknown Otis Huff

14. MOTHER'S MAIDEN NAME

unknown Fannie Peoples

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)

Yes

(If yes, give war or dates of service)

World War 2

16. SOCIAL SECURITY NO.

218-05-4009

17. INFORMANT

Eloa Huff 1618 Latrobe St

ADDRESS

18. CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)

(A) Asphyxia due to hanging

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

jail

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

Northeastern District Jail

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

December 5, 1950 3 p. m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR?

Hanged self from bar on door with belt

22. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐.

23A. SIGNATURE

Stanley S. Dunleavy M.D.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☒

23C. DATE SIGNED

Dec. 6, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

Dec. 8/50

24C. NAME OF CEMETERY OR CREMATORY

Beth. National Cem.

24D. LOCATION (City, town, or county)

Fredrick Rd.

(State)

Md.

DATE RECEIVED BY LOCAL REGISTRAR

DEC 6 - 1950

REGISTRAR'S SIGNATURE

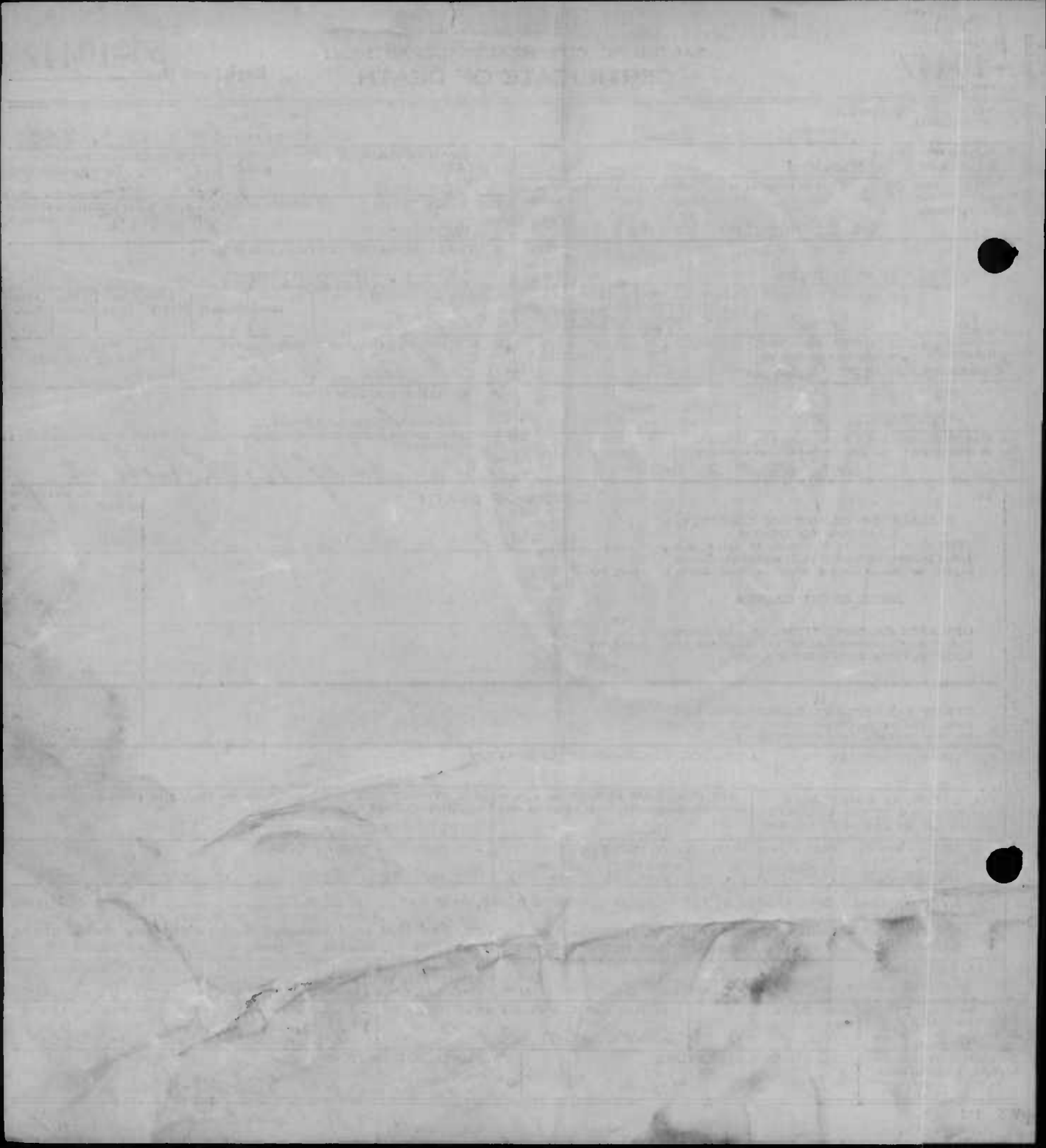
William Williams, M.D.

25. FUNERAL DIRECTOR

Mrs. Robert A. Elliott, Daughter

ADDRESS

1129 N. Caroline St. 1642



620
50-10448
BIRTH NO.HORSEY
BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50-10448
Registered No.

1. NAME OF DECEASED (Type or Print) <i>Ellen Hansey</i>			2. DATE OF DEATH <i>December 5, 1950</i>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY		
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>THE JOHNS HOPKINS HOSPITAL</i>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore</i>		
c. Length of stay in Baltimore <i>Life</i>			D. STREET ADDRESS (If rural, give location) <i>1819 E. Eager St.</i>		
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Colored</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Married</i>	8. DATE OF BIRTH <i>7-7-24</i>		9. AGE (In years last birthday) <i>26</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>Beth. Md.</i>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <i>Lockerman M. Cready</i>			14. MOTHER'S MAIDEN NAME <i>Sola Keene</i>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS <i>THE JOHNS HOPKINS HOSPITAL</i>		

18. <i>570.1</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <i>PERITONITIS, UREMIA, CARDIAC DECOMPENSATION</i>	CAUSE OF DEATH (A) <i>PERITONITIS, UREMIA, CARDIAC DECOMPENSATION</i> DUE TO (B) <i>PERFORATION OF ILEUM</i> DUE TO (C) <i>Intestinal obstruction</i>	INTERVAL BETWEEN ONSET AND DEATH <i>8 days</i>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <i>None</i>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>None</i>		

19A. DATE OF OPERATION <i>11/30/50</i>	19B. MAJOR FINDINGS OF OPERATION <i>Perforation of ileum - Intestinal obstruction</i>	20. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>None</i>	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *11-30*, 19*50*, to *12-5*, 19*50*, that I last saw the deceased alive on *12-5*, 19*50*, and that death occurred at *645* p.m., from the causes and on the date stated above.

23A. SIGNATURE <i>W. H. H. H.</i>		23B. ADDRESS <i>THE JOHNS HOPKINS HOSPITAL</i>	23C. DATE SIGNED <i>12/6/50</i>
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>Dec 6</i>	24C. NAME OF CEMETERY OR CREMATORY <i>Bethel National Cem.</i>	24D. LOCATION (City, town, or county) (State) <i>Frederick Rd. Md.</i>
DATE RECEIVED BY LOCAL REGISTRAR <i>DEC 6 - 1950</i>	REGISTRAR'S SIGNATURE <i>W. H. H. H.</i>	25. FUNERAL DIRECTOR ADDRESS <i>Mrs. Robert G. Elliott Daughters</i> <i>1129 N. Caroline St.</i>	

Report of the
Investigation

of the
Flood

8 days

1/2 of the population of the United States

1900

1900

500
50-10449BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50-10449
Registered No.

1. NAME OF DECEASED (Type or Print) JOHN S. SISELBERGER ROWAN			2. DATE OF DEATH Dec 5, 1950		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY		
B. FULL NAME OF HOSPITAL OR INSTITUTION 3704 Mohawk Avenue			C. CITY OR TOWN (If outside corporate limits, write full name, and give township) Baltimore		
c. Length of stay in Baltimore 62 Yrs. Mos. Days			D. STREET ADDRESS (If rural, give location) 3704 Mohawk Avenue		
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Oct. 15, 1888	9. AGE (In years last birthday) 62	10. Under 1 Year Months Days 11. Under 24 Hours Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Executive			12. CITIZEN OF WHAT COUNTRY? United States		
13. FATHER'S NAME John H. D. Rowan			14. MOTHER'S MAIDEN NAME Margaret Lelia Sisselberger		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
17. INFORMANT Mrs. Bessie Rowan			ADDRESS 3704 Mohawk Ave - 7 -		

18. 450.0 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Uraemia CAUSE OF DEATH (A) DUE TO Generalized Arteriosclerosis (B) DUE TO Thrombophlebitis both legs (C) DUE TO	INTERVAL BETWEEN ONSET AND DEATH 72 hours 15 years 15 yrs
--	---

19A. DATE OF OPERATION 0		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Dec. 8, 1949 , to Dec. 5, 1950 , that I last saw the deceased alive on Dec. 4, 1950 and that death occurred at 3:30 A.M. , from the causes and on the date stated above.					
23A. SIGNATURE William T. Ireland		23B. ADDRESS 3400 Woodbine Ave. Balt 2 Md		23C. DATE SIGNED 12/5/50	
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE Dec 7, 1950		24C. NAME OF CEMETERY OR CREMATORY Louisa Park Cemetery, Balt.	
24D. LOCATION (City, town, or county) (State)		24E. NAME OF CEMETERY OR CREMATORY		24F. LOCATION (City, town, or county) (State)	
DATE RECEIVED BY LOCAL REGISTRAR DEC 6 - 1950		REGISTRAR'S SIGNATURE William T. Ireland		FUNERAL DIRECTOR William T. Ireland ADDRESS 4510 Liberty Heights Ave	

**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

Registered No. **50-10450**

50-10450
BIRTH NO.

1. NAME OF DECEASED (Type or Print) Grace E. Williamson			2. DATE OF DEATH Dec. 5, 1950		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE Maryland B. COUNTY none		
B. FULL NAME OF HOSPITAL OR INSTITUTION Homewood Apts.			C. CITY OR TOWN Baltimore (If outside corporate limits, write RURAL and give township)		
c. Length of stay in Baltimore 50 Yrs. Mos. Days			D. STREET ADDRESS (If rural, give location) Homewood Apartments, Charles & 31st Sts.		
5. SEX female	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) widowed	8. DATE OF BIRTH Aug. 7, 1876		9. AGE (In years last birthday) 74
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none			11. BIRTHPLACE (State or foreign country) Delaware		12. CITIZEN OF WHAT COUNTRY? U. S.
13. FATHER'S NAME ? Greenwood			14. MOTHER'S MAIDEN NAME ?		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS Mrs. Martha W. Keller 306 Grove Boulevard Frederick, Maryland		

18. 420.0 CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) (A) Coronary thrombosis		10 min.
DUE TO		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) Arteriosclerotic heart disease		2 yr.
(C) Hypertensive C.V. disease		5 yr.
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH no		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from **Oct 13, 1950**, to **Dec 5, 1950**, that I last saw the deceased alive on **Oct 13, 1950**, and that death occurred at **3 P.m.**, from the causes and on the date stated above.

23A. SIGNATURE Roman R. Freeman, M.D.	23B. ADDRESS 11 W. 29th St.	23C. DATE SIGNED Dec 6, 1950
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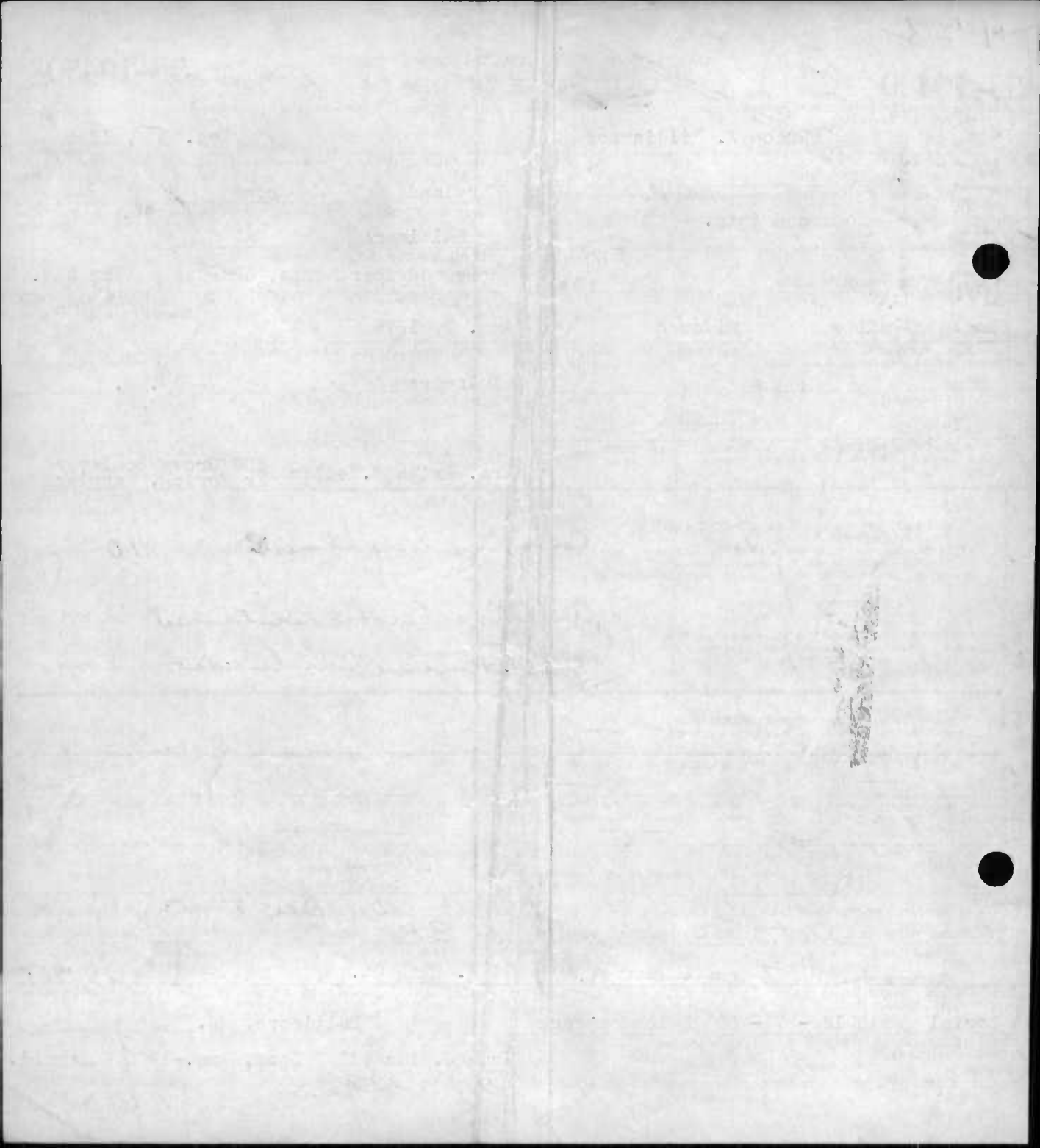
24A. BURIAL, CREMATION, REMOVAL (Specify) burial	24B. DATE 12 - 7 - 50	24C. NAME OF CEMETERY OR CREMATORY Loudon Park	24D. LOCATION (City, town, or county) (State) Baltimore, Md.
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DATE RECEIVED BY LOCAL REGISTRAR DEC 6 - 1950	REGISTRAR'S SIGNATURE <i>[Signature]</i>	25. FUNERAL DIRECTOR ADDRESS John O. Mitchell & Sons, Inc. - 1900 Eutaw Pl.
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Dr. Freeman

93D

MEDICAL CERTIFICATION



425
50-10451

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10451
Registered No.

1. NAME OF DECEASED (Type or Print) ALICE WILSON		2. DATE OF DEATH 12/5/50	
3. PLACE OF DEATH: A. Baltimore City, Maryland Balt. City		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION Maryland Gen. Hosp		C. CITY OR TOWN (If outside corporate limits, write full name, and give township) Baltimore	
c. Length of stay in Baltimore Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) 1907 Oak Hill Ave Balt.	
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH Nov. 11, 1886
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10B. KIND OF BUSINESS OR INDUSTRY own home	9. AGE (In years last birthday) 74
13. FATHER'S NAME Conrad Gable		11. BIRTHPLACE (State or foreign country) Glen Rock Pa.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		12. CITIZEN OF WHAT COUNTRY?	
16. SOCIAL SECURITY NO.		14. MOTHER'S MAIDEN NAME Barbara Zeiber	
17. INFORMANT Charles H. Wilson		ADDRESS 1907 Oak Hill Ave.	
18. 331X and E900.0 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Cerebral Hemorrhage DUE TO Antecedent Causes DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Concussion Multibacillosis		INTERVAL BETWEEN ONSET AND DEATH 1 month 1 month	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CERTIFICATION APPROVED BY [Signature] M.D. CHIEF OR ASST. MEDICAL EXAMINER	
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH	
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) home		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 1907 Oak Hill Avenue	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY October 29, 1950 ? m.		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
21F. HOW DID INJURY OCCUR? Fell down steps in home		22. I hereby certify that I attended the deceased from 11/21 , 19 50 , to 12/5 , 19 50 , that I last saw the deceased alive on 12/5 , 19 50 , and that death occurred at 9:00 p.m. , from the causes and on the date stated above.	
23A. SIGNATURE Anthony C. Vernon M.D.		23B. ADDRESS Maryland Gen. Hosp	
23C. DATE SIGNED 12/10/50		24A. BURIAL, CREMATION, REMOVAL (Specify) Burial	
24B. DATE 12/8/50		24C. NAME OF CEMETERY Parkwood	
24D. LOCATION (City, town, or county) Parkville, Md.		24E. LOCATION (State) Md.	
DATE RECEIVED BY LOCAL REGISTRAR DEC 6 - 1950		REGISTRAR'S SIGNATURE [Signature]	
25. FUNERAL DIRECTOR Wm. Cook, Inc.		ADDRESS 1217 St. Paul St.	

10131

455
50-10452

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50-10452

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Howard Garland CLEMENTS, Jr.

2. DATE
OF
DEATH

DEC 6, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION

Mercy Hospital

C. Length of stay in Baltimore

Life

Yrs.
Mos.
Days

5. SEX

male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

Feb 18, 1932

9. AGE (In years
last birthday)

18

10. Under 1 Year
Months: Days

11. Under 24 Hours
Hours: Min.

10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Student

10B. KIND OF BUSINESS OR
INDUSTRY

HOPKINS

13. FATHER'S NAME

Howard G. Clements, Jr.

11. BIRTHPLACE (State or foreign country)

Baltimore, Md

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

14. MOTHER'S MAIDEN NAME

Flourence A. Holt

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

17. INFORMANT

Father

ADDRESS

Same

18. 2041

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A)

Leukemia, Myelocytic
Leukemia

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

Pancytopenia c myeloid
crisis

(C)

3 mos?

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

none

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT ☐ NOT WHILE ☐
WORK AT WORK

22. I hereby certify that I attended the deceased from Dec 3, 1950, to Dec 6, 1950, that I last saw the
deceased alive on Dec 6, 1950, and that death occurred at 7:05 AM., from the causes and on the date stated above.

23A. SIGNATURE

Philip W. Duemmler M. D.

23B. ADDRESS

Mercy Hosp

23C. DATE SIGNED

12-6-50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

Burial

12/8/50

Greenmount

Balt

Md

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

DEC 6 - 1950

Huntington Williams, Jr.

L. J. Luck

5305 Harford Rd

MEDICAL CERTIFICATION

Sperry, Texas:

Deficiency of the
cell elements of the blood
(aplastic anemia)

myeloid:

pertaining to, derived from
or resembling bone marrow.

432
50-10453BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50-10453

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Schultz, William Rogers			2. DATE OF DEATH December 5, 1950		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY		
B. FULL NAME OF HOSPITAL OR INSTITUTION St. Joseph's			C. CITY OR TOWN (If outside corporate limits, write full name and give township) Baltimore		
c. Length of stay in Baltimore			D. STREET ADDRESS (If rural, give location) 544 Benninghouse Rd.		
5. SEX M.	6. COLOR OR RACE W.	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Divorced	8. DATE OF BIRTH Sept. 23 - 1895	9. AGE (In years last birthday) 55 If Under 1 Year: Months: Days If Under 24 Hours: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Watchman		10B. KIND OF BUSINESS OR INDUSTRY Construction Co.		11. BIRTHPLACE (State or foreign country) Baltimore Md	
13. FATHER'S NAME Frederick W. Schultz			12. CITIZEN OF WHAT COUNTRY USA		
15. WAS DECEASED EVER IN U. S. ARMED FORCES (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
14. MOTHER'S MAIDEN NAME Melrina C. Rogers			17. INFORMANT Mrs. Gertrude O'Keefe		
18. WAS DECEASED EVER IN U. S. ARMED FORCES (Yes, no or unknown) (If yes, give war or dates of service)			ADDRESS 3413 Brandon		

18. 490X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Lobar pneumonia, right		INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Arteriosclerotic heart disease with congestive heart failure		
19A. DATE OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY
21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **November 28, 1950**, to **December 5, 1950**, that I last saw the deceased alive on **12-4**, 19 **50**, and that death occurred at **6:40 A.M.**, from the causes and on the date stated above.

23A. SIGNATURE Thaddens Swinski		23B. ADDRESS 1100 N. Caroline St.		23C. DATE SIGNED Dec. 5, 1950	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial	24B. DATE 12/8/50	24C. NAME OF CEMETERY OR CREMATORY Parkwood	24D. LOCATION (City, town, or county) (State) Balt, Md		
DATE RECEIVED BY LOCAL REGISTRAR DEC 6 - 1950		REGISTRAR'S SIGNATURE William W. Williams		25. FUNERAL DIRECTOR L. J. Luck	
				ADDRESS 5305 Harford Rd	

10-10-1913

10-10-1913

STATE OF NEW YORK
OFFICE OF THE ATTORNEY GENERAL

IN SENATE,
January 10, 1913.

REPORT
OF THE
COMMISSIONER OF THE LAND OFFICE,
IN RESPONSE TO A RESOLUTION
PASSED BY THE SENATE,
MAY 1, 1912.

ALBANY:
J. B. LEECH, PRINTERS,
1913.

120
50-10454
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10454
Registered No.

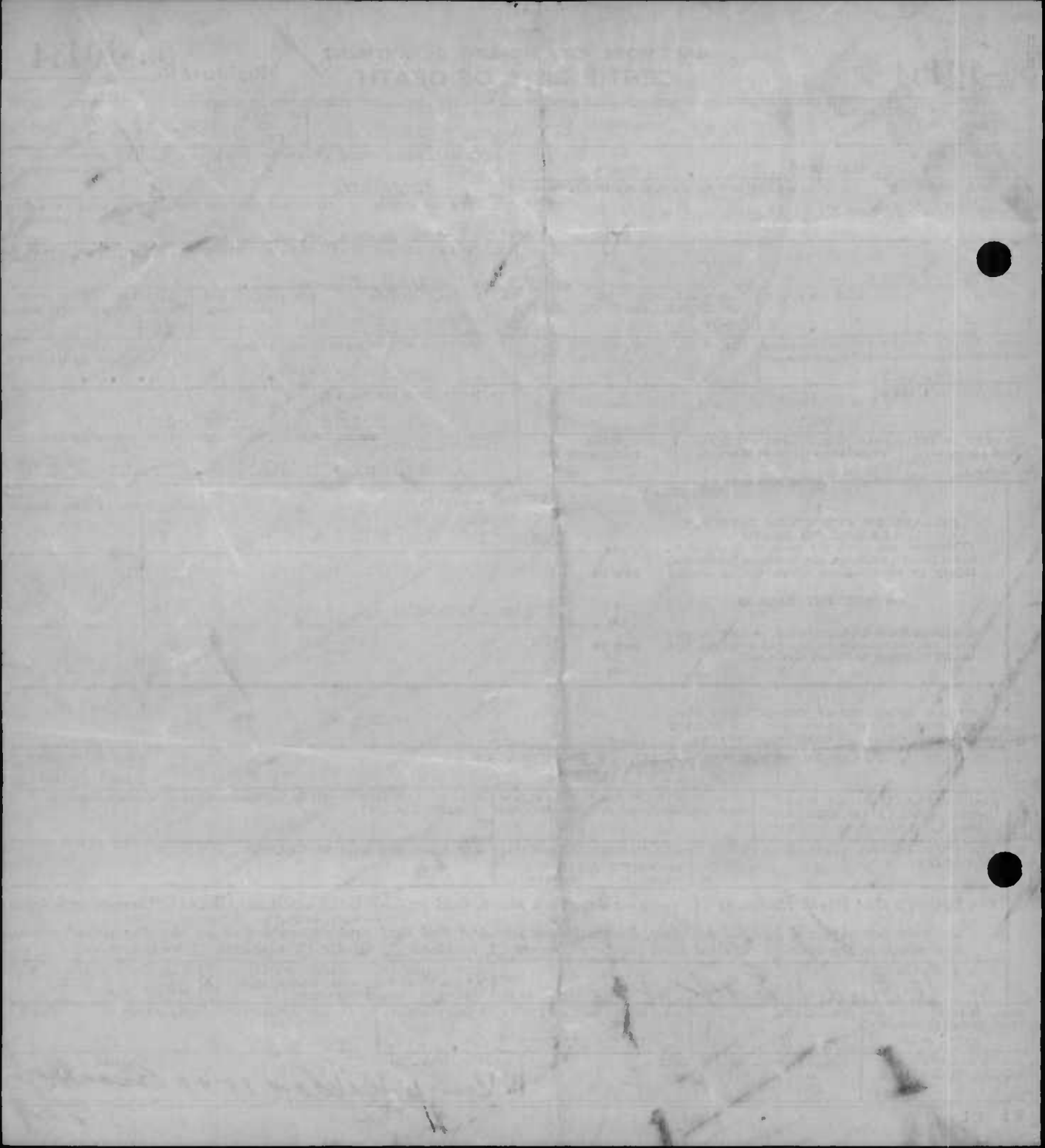
1. NAME OF DECEASED (Type or Print) Mary Bryan Sephus			2. DATE OF DEATH Dec. 3, 1950		
3. PLACE OF DEATH: A. BALTIMORE CITY, Maryland Balto. City			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY		
B. FULL NAME OF (If not in hospital or institution, give street address or location) Johns Hopkins Hospital			C. CITY OR TOWN (If outside corporate limits write RURAL and give township) Baltimore		
C. LENGTH OF STAY IN BALTIMORE Life			D. STREET ADDRESS (If rural, give location) 424 N. Chapel St.		
5. SEX Female	6. COLOR OR RACE Col.	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Separated	8. DATE OF BIRTH II/25/1886	9. AGE (In years last birthday) 64	10. Under 1 Year Months: Days: 11. Under 24 Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY At home	11. BIRTHPLACE (State or foreign country) Baltimore Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Unknown			14. MOTHER'S MAIDEN NAME Catherine Armstrong		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS Edna Jackson 1624 E. Pratt St		

18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Rheumatic Heart Disease (A) DUE TO ANTECEDENT CAUSES Aortic Stenosis (B) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (C) II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	INTERVAL BETWEEN ONSET AND DEATH
--	----------------------------------

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	

22. I certify that I took charge of the remains described above, held an Inspection & Inquiry thereon and from Autopsy, Inspection or Inquiry the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE William V. Lantz		23B. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> M.D. MEDICAL INVESTIGATOR <input type="checkbox"/>		23C. DATE SIGNED Dec. 4, 1950	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial	24B. DATE 12/7/1950	24C. NAME OF CEMETERY OR CREMATORY Mt Calvary Cem.	24D. LOCATION (City, town, or county) (State) Brooklyn Md		
DATE RECEIVED BY LOCAL REGISTRAR DEC 6 - 1950	REGISTRAR'S SIGNATURE William V. Lantz	25. FUNERAL DIRECTOR Elroy Wilson 1000 Beatty		ADDRESS	



CERTIFICATE OF DEATH

50-10455

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print)

EARLINE
Arlene Botts or Earlene c Botts

2. DATE OF DEATH

12-3-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)

113 Welcome Al.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

113 Welcome Al.

C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township)

Baltimore MD 22-01

D. STREET ADDRESS (If rural, give location)

113 Welcome Al.

C. Length of stay in Baltimore

Life

5. SEX

F

6. COLOR OR RACE

Col

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

8. DATE OF BIRTH

June 11th/50

9. AGE (In years last birthday)

5- Months: Days: Hours: Min.

11. BIRTHPLACE (State or foreign country)

Baltimore MD.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Melvin Botts

14. MOTHER'S MAIDEN NAME

Almelia Botts

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Almelia Botts mother

18. E 921.0

CAUSE OF DEATH

113 Welcome Al.

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) Aspiration of Vomit

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH. BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

113 Welcome Alley

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

Dec. 3, 1950

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

Aspiration of vomitus

22. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural cause ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐.

23A. SIGNATURE

William V. Botts

23B. CHIEF MEDICAL EXAMINER

23C. DATE SIGNED

M.D.

ASSISTANT MEDICAL EXAMINER

12-3-50

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

DEC 6 - 1950

Wm. V. Botts

Chas. O. W. Elam

7-10-1977

STATE OF DEATH



**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

50-10456

Registered No. _____

500
50-10456
BIRTH NO.

1. NAME OF DECEASED (Type or Print) A. Edna Jean			2. DATE OF DEATH Dec. 5, 1950		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY _____		
B. FULL NAME OF HOSPITAL OR INSTITUTION 2105 Mt. Holly St.,			C. CITY OR TOWN (If outside corporate limits, write R.R. No. and give township) Baltimore		
C. Length of stay in Baltimore Yrs. _____ Mos. _____ Days _____			D. STREET ADDRESS (If rural, give location) 2105 Mt. Holly St.,		
5. SEX F.	6. COLOR OR RACE W.	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Feb. 5, 1886	9. AGE (In years last birthday) 64	10. Under 1 Year Months _____ Days _____ 11. Under 24 Hours Hours _____ Min. _____
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-wife			11. BIRTHPLACE (State or foreign country) Md.		
13. FATHER'S NAME James Bathgate			14. MOTHER'S MAIDEN NAME Anna E. Parlett		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no			16. SOCIAL SECURITY NO. none		
			17. INFORMANT ADDRESS Norval L. Jean 2105 Mt. Holly St.,		

18. 171X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	CAUSE OF DEATH (A) Carcinoma of cervix, uterine metastases to retroperitoneal lymph glands DUE TO (B) _____ DUE TO (C) _____	INTERVAL BETWEEN ONSET AND DEATH 10 mo.
--	--	---

19A. DATE OF OPERATION 0		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 2/3 19 47 , to 12/5 , 19 50 that I last saw the deceased alive on 12/4 , 19 50 , and that death occurred at 1354 a. m., from the causes and on the date stated above.					
23A. SIGNATURE Robert A. Renter		23B. ADDRESS 3408 Windsor Ave		23C. DATE SIGNED 12/6/50	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-7-1950		24C. NAME OF CEMETERY OR CREMATORY Loudon Park	
24D. LOCATION (City, town, or county) (State) Baltimore Md.		25. FUNERAL DIRECTOR ADDRESS G. Howard Strong 3207 W. North Ave.,			

Dr. Reiter

**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

Registered No.

50-104

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

James A. Sullivan

DATE
OF
DEATH

Dec. 3, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If residence before admission)

A. STATE

Md.

B. COUNTY

5. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR INSTITUTION

1332 S. Charles St.

C. CITY OR TOWN

Balto.

(If outside corporate limits, write Rural and give township)

6. STREET ADDRESS (If rural, give location)

1332 S. Charles St.

Length of stay in Baltimore

Life

Yrs.
Mos.
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

widower

8. DATE OF BIRTH

Feb. 7, 1867

9. AGE (In years last birthday)

83 yrs

If Under 1 Year If Under 24 Hours

Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Carpenter

10B. KIND OF BUSINESS OR INDUSTRY

Self-Employed

11. BIRTHPLACE (State or foreign country)

Balto. Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Michael Sullivan

14. MOTHER'S MAIDEN NAME

Mary Ellen Kane

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL SECURITY NO.

none

17. INFORMANT

Joseph Kelly

ADDRESS

1332 S. Charles St

18. *422 1*

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) *Arteriosclerotic Cardio-Vascular Disease*

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an *Inspection* thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

W. M. H. Kammer, Jr.

M.D.

23B. CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

MEDICAL INVESTIGATOR ☒

23C. DATE SIGNED

Dec. 4, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

Dec. 7, 1950

24C. NAME OF CEMETERY OR CREMATORY

New Cathedral

24D. LOCATION (City, town, or county) (State)

Old Frederick Rd. Balto Md

REGISTRAR'S SIGNATURE

Huntington Williams, Jr.

25. FUNERAL DIRECTOR

Krause Funeral Home 939

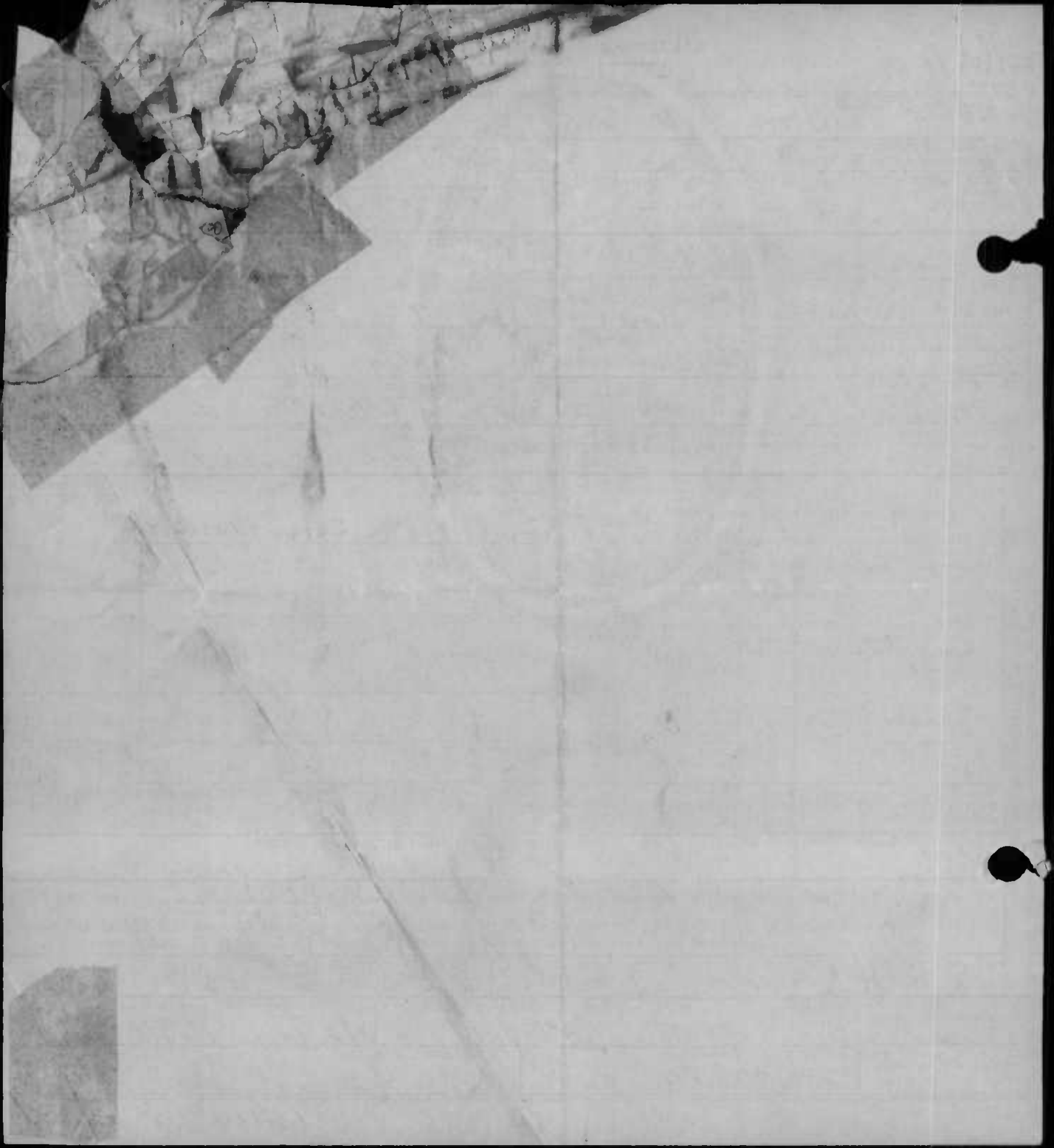
ADDRESS

1216 S. Charles St. Balto 30

DEC 6 - 1950

VS 151

MEDICAL CERTIFICATION



610
50-10458BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50-10458

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <i>Minnie Louise KERBE</i>			2. DATE OF DEATH <i>DEC. 5, 1950</i>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MARYLAND</i> B. COUNTY <i>20-04</i>		
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>153 S. WILLARD ST.</i>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>BALTIMORE</i>		
c. Length of stay in Baltimore <i>62 yrs</i>			D. STREET ADDRESS (If rural, give location) <i>153 S. WILLARD ST.</i>		
5. SEX <i>FEMALE</i>	6. COLOR OR RACE <i>WHITE</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Widow</i>	8. DATE OF BIRTH <i>JAN. 10, 1886</i>	9. AGE (In years last birthday) <i>64</i>	10. Under 1 Year Months: Days: 11. Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Domestic</i>	11. BIRTHPLACE (State or foreign country) <i>GERMANY</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>
13. FATHER'S NAME <i>HENRY WAGENER</i>			14. MOTHER'S MAIDEN NAME <i>ROSINA WAGENER</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO. <i>NONE</i>	17. INFORMANT ADDRESS <i>MARIE L. WELSH 153 WILLARD ST.</i>		

18. <i>443 X</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	CAUSE OF DEATH (A) <i>Pulmonary Edema</i> DUE TO (B) <i>Hypertensive Cordis Pulmonis</i> DUE TO (C) _____	INTERVAL BETWEEN ONSET AND DEATH
--	--	----------------------------------

19A. DATE OF OPERATION <i>0</i>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>Oct 15</i> , 19 <i>50</i> , to <i>Dec 5</i> , 19 <i>50</i> , that I last saw the deceased alive on <i>Dec 5</i> , 1950, and that death occurred at <i>8 A.</i> m., from the causes and on the date stated above.					
23A. SIGNATURE <i>Robert C. Welch</i>		23B. ADDRESS M. D. <i>3157 W. ...</i>		23C. DATE SIGNED <i>12-5-50</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	24B. DATE <i>12-8-50</i>	24C. NAME OF CEMETERY OR CREMATORY <i>LONDON PARK</i>	24D. LOCATION (City, town, or county) (State) <i>BALTIMORE MD.</i>		
DATE RECEIVED BY LOCAL REGISTRAR <i>DEC 8 1950</i>		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR ADDRESS <i>Geo. L. Schwab 2101 Frederick Ave</i>	

B-400
50-10459BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHX
50-10459
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Edward Morris Bell

2. DATE
OF
DEATH

12-6-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution: residence
before admission)

A. STATE

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or
HOSPITAL OR location)
INSTITUTION

Union Memorial Hospital

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Freeland

D. STREET ADDRESS (If rural, give location)

833 South St.

C. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

M

B. DATE OF BIRTH

11-11-87

9. AGE (in years
last birthday)

63

If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of worklog life, even if retired)

Supt. Water Co.

10B. KIND OF BUSINESS OR
INDUSTRY

Water Supply Co.

11. BIRTHPLACE (State or foreign country)

USA Penna.

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

John Bell

14. MOTHER'S MAIDEN NAME

Margaret Harris

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

Unknown

16. SOCIAL
SECURITY NO.

17. INFORMANT

Mrs. E.H. Bell, wife

ADDRESS

Same

18.

4201 I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A)

Coronary occlusion

DUE TO

INTERVAL BETWEEN
ONSET AND DEATH

7 wks

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

0

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10-14, 1950, to 12-6, 1950, that I last saw the
deceased alive on 12-6, 1950, and that death occurred at 1033A., from the causes and on the date stated above.

23A. SIGNATURE

Alvin Bonplac

M. O.

23B. ADDRESS Union Memorial Hosp

3324 Calvert St.

23C. DATE SIGNED

12-6-50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

12-10-50

24C. NAME OF CEMETERY OR CREMATORY

Freeland Cem.

24D. LOCATION (City, town, county)

Freeland, Pa.

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

Charles S. Zeiler

ADDRESS

901 S. Banklun
St.

DEC 6-1950

290 5F

94a

[Faint handwritten notes at the bottom of the page]

J-520 50-10460

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10460

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Bratten Jones

2. DATE
OF
DEATH

12-4-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, If institution: residence
before admission)

A. STATE

B. COUNTY

Md.

5. FULL NAME OF (If not in hospital or institution, give street address or
HOSPITAL OR location)
INSTITUTION

Md. Gen. Hosp.

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Balto

6. Length of stay in Baltimore

Yrs.
Mos.
Days

D. STREET ADDRESS (If rural, give location)

614 W. Patmore St. 7-01

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

M

8. DATE OF BIRTH

1 July 1888

9. AGE (in years
last birthday)

62

If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Night Watchman

10B. KIND OF BUSINESS OR
INDUSTRY

Furniture Company

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

George Jones

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

218-18-3016

17. INFORMANT

ADDRESS

Gertrude M. Jones - 614 W. Patmore St.

18. 181X

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A)

Anemia

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CAUSE LAST.

(B)

Anemia

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

Pulmonary edema

19A. DATE OF OPERATION

11-29-50

19B. MAJOR FINDINGS OF OPERATION

Ca of bladder

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT WAS UNDER-
LYING OR CONTRIBUTING
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11-29, 1950, to 12-4, 1950, that I last saw the
deceased alive on 12-4, 1950, and that death occurred at 11:20 p. m., from the causes and on the date stated above.

23A. SIGNATURE

W. K. Bruden

M. D.

23B. ADDRESS

Md. Gen. Hosp.

23C. DATE SIGNED

12-5-50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

12-8-50

24C. NAME OF CEMETERY OR CREMATORY

Jerusalem Cemetery

24D. LOCATION (City, town, or county)

4603 Belair Road

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

William D. Miller

25. FUNERAL DIRECTOR

ADDRESS

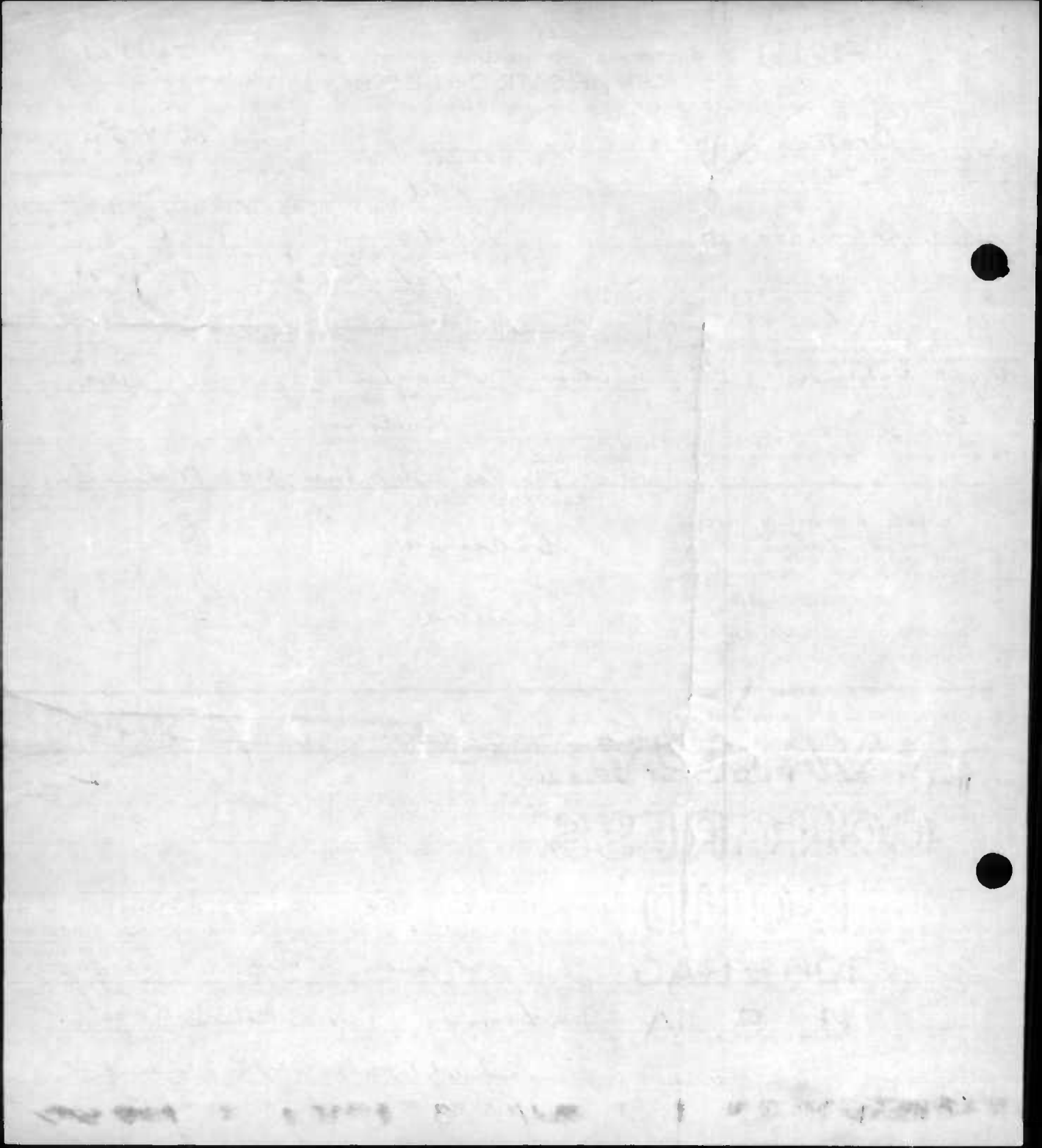
Frederick D. Miller + 3019 E. Monument St

DEC 8 1950

763 33

52 B

MEDICAL CERTIFICATION



650
9-10461BROWN
BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50-10461

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <i>Samuel Brown</i>			2. DATE OF DEATH <i>12-5-50</i>		
3. PLACE OF DEATH: a. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>md</i> B. COUNTY <i>Carroll</i>		
b. FULL NAME OF HOSPITAL OR INSTITUTION <i>Community Hospital</i>			c. CITY OR TOWN <i>Mt Airy</i>		
c. Length of stay in Baltimore <i>4</i>			d. STREET ADDRESS (If rural, give location) <i>5600</i>		
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Married</i>	8. DATE OF BIRTH <i>Feb. 3, 1906</i>	9. AGE (in years last birthday) <i>44</i>	10. Under 1 Year Months: Days: Hours: Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Carpenter</i>			10b. KIND OF BUSINESS OR INDUSTRY <i>B. & O. R. R.</i>		
11. BIRTHPLACE (State or foreign country) <i>md.</i>			12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		
13. FATHER'S NAME <i>John S. Brown</i>			14. MOTHER'S MAIDEN NAME <i>Amelia Giles</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>no</i>			16. SOCIAL SECURITY NO. <i>214-18-1683</i>		
17. INFORMANT <i>Mrs Marie Brown</i>			ADDRESS <i>Mt. Airy, md.</i>		

18. <i>154X</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Intestinal carcinoma</i> DUE TO <i>Carcinoma of rectum</i> DUE TO <i>Carcinoma of rectum</i>	INTERVAL BETWEEN ONSET AND DEATH <i>5 months</i>
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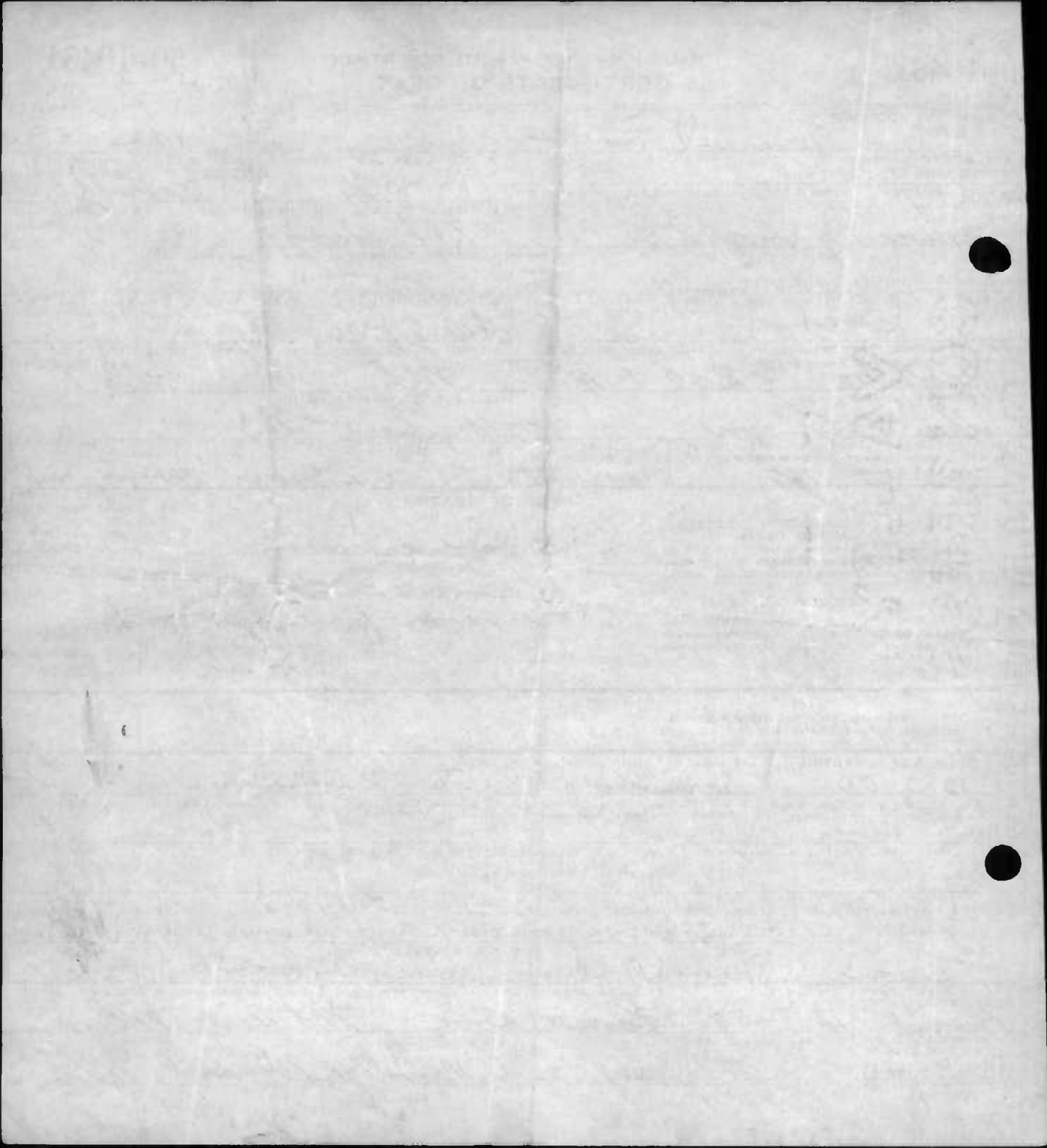
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19a. DATE OF OPERATION <i>12-2-50</i>	19b. MAJOR FINDINGS OF OPERATION <i>Carcinoma of rectum - metastases</i>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>	21b. PLACE OF INJURY (e. g., at or about home, farm, factory, street, office bldg., etc.) <input type="checkbox"/>	21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <input type="checkbox"/>
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <input type="checkbox"/>	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <input type="checkbox"/>

22. I hereby certify that I attended the deceased from *12-1*, 19*50*, to *12-5*, 19*50* that I last saw the deceased alive on *12-5*, 19*50*, and that death occurred at *7 a.m.*, from the causes and on the date stated above.

23a. SIGNATURE <i>Edward J. Broadbent</i>	23b. ADDRESS <i>University Hospital</i>	23c. DATE SIGNED <i>12-5-50</i>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	24b. DATE <i>12-8-50</i>	24c. NAME OF CEMETERY OR CREMATORY <i>Pine Grove</i>	24d. LOCATION (City, town, or county) (State) <i>Mt Airy, md.</i>
DATE RECEIVED BY LOCAL REGISTRAR <i>DEC 7 - 1950</i>	REGISTRAR'S SIGNATURE <i>William M. Williams</i>	25. FUNERAL DIRECTOR <i>C. M. Wertz - Winfield, md.</i>	ADDRESS <i>Winfield, md.</i>



**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

50-10462
Registered No.

250
50-10462
BIRTH NO.

1. NAME OF DECEASED (Type or Print) CATHERINE J. HOGAN			2. DATE OF DEATH 12-5-1950		
3. PLACE OF DEATH: A. Baltimore City, Maryland BALTIMORE			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY		
B. FULL NAME OF HOSPITAL OR INSTITUTION WINDSOR REST HOME 025 WINDSOR AVE BALTIMORE			C. CITY OR TOWN BALTIMORE (If outside corporate limits, write FULL name and give township)		
C. Length of stay in Baltimore 74 yrs.			D. STREET ADDRESS (If rural, give location) 3025 WINDSOR AVE		
5. SEX FEMALE	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH 4/13/1876		9. AGE (In years, last birthday) 74
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY A HOME	11. BIRTHPLACE (State or foreign country) Baltimore Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME PATRICK WARD			14. MOTHER'S MAIDEN NAME ANN FITZPATRICK ✓		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no		16. SOCIAL SECURITY NO. None	17. INFORMANT ADDRESS Mr. John P. Guckert 1232 Windsor Rd.		

18. 491X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Bronchopneumonia			CAUSE OF DEATH 2 days		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.			(B) DUE TO		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			(C) DUE TO		
19A. DATE OF OPERATION 0		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 2/1 , 19 50 , to 12/5 , 19 50 that I last saw the deceased alive on 12/4 , 19 50 , and that death occurred at 3:30 p. m., from the causes and on the date stated above.					
23A. SIGNATURE Robert A. Reiter		23B. ADDRESS 3408 Windsor Ave		23C. DATE SIGNED 12/6/50	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-7-1950		24C. NAME OF CEMETERY OR CRIMATORY New Cathedral Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.		25. FUNERAL DIRECTOR ADDRESS Edmer W. Conklin 924 E. Eager St.			

Dr. Robert K. Kuter
Garrison Blvd & Windsor Ave

620

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10463

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Frederick H George

2. DATE
OF
DEATH

Dec. 6, 1950

3. PLACE OF DEATH:

a. Baltimore City, Maryland

BALTO

b. FULL NAME OF
HOSPITAL OR
INSTITUTION (If not in hospital or institution, give street address or location)

6621 Fairdel Ave

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

a. STATE

b. COUNTY

before admission)

Md

c. CITY OR TOWN

(If outside corporate limits, give RURAL and give township)

BALTO

d. STREET ADDRESS (If rural, give location)

6621 Fairdel Ave

c. Length of stay in Baltimore

Life

Yrs.
Mos.
Days

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

April 14, 1892

9. AGE (in years,
last birthday)

58

If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.10a. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Pensacola Conductor

10b. KIND OF BUSINESS OR
INDUSTRY

B & O - RR

11. BIRTHPLACE (State or foreign country)

BALTO. CITY MD

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Henry L. George

14. MOTHER'S MAIDEN NAME

Amelia Schroeder

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

705-09-4987

17. INFORMANT

ADDRESS BALTO

Mrs. F. H George 6621 Fairdel Ave MD

18. 420.1

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) Acute coronary occlusion

DUE TO

1/2 hr.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) Hypertension arteriosclerotic C.V.D.

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21a. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21b. PLACE OF INJURY (e.g., in or
about home, farm, factory, street, office bldg., etc.)21c. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21d. TIME (Month) (Day) (Year) (Hour)
INJURY

21e. INJURY OCCURRED

21f. HOW DID INJURY OCCUR?

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22. I hereby certify that I attended the deceased from Feb., 1946, to Dec. 6, 1950, that I last saw the deceased alive on Nov., 1950, and that death occurred at 6:55 a.m., from the causes and on the date stated above.

23a. SIGNATURE

M. D.

23b. ADDRESS

23c. DATE SIGNED

24a. BURIAL, CREMA-
TION, REMOVAL (Specify)

24b. DATE

24c. NAME OF CEMETERY OR CREMATORY

24d. LOCATION (City, town, or county) (State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

DEC 7 - 1950

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

MEDICAL CERTIFICATION

10-10-63

UNITED STATES DEPARTMENT OF COMMERCE

OFFICE OF THE SECRETARY

10-10-63



632
50-10464
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10464
Registered No.

1. NAME OF DECEASED (Type or Print) MARTHA SCHRATKE			2. DATE OF DEATH December 5, 1950		
3. PLACE OF DEATH: A. Baltimore City, Maryland St. Joseph's Hospital B. FULL NAME OF HOSPITAL OR INSTITUTION St. Joseph's Hospital			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland C. CITY OR TOWN Baltimore D. STREET ADDRESS (If rural, give location) 5728 Belair Road		
5. SEX female	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH 2/19/79	9. AGE (In years last birthday) 71	10. Under 1 Year Months: Days: 11. Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home			10B. KIND OF BUSINESS OR INDUSTRY Own home		
11. BIRTHPLACE (State or foreign country) Germany			12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME Christian Schratke			14. MOTHER'S MAIDEN NAME Marie Baunch		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
17. INFORMANT Mrs. J. Elmer Hofstetter			ADDRESS 4023 Frankford Ave.		

18. E 812.4 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Multiple fractures and contusions DUE TO Fracture of left leg and dorsal vertebra	INTERVAL BETWEEN ONSET AND DEATH
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) street		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) White Avenue and Belair Road	
21D. TIME (Month) (Day) (Year) (Hour) December 4, 1950 5.30p.m.		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? Pedestrian struck by auto	
22. I certify that I took charge of the remains described above, held an Inquiry & Inspection thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input checked="" type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .					
23A. SIGNATURE Stanley H. Dunlocher		23B. CHIEF MEDICAL EXAMINER..... ASSISTANT MEDICAL EXAMINER..... MEDICAL INVESTIGATOR.....		23C. DATE SIGNED Dec. 5, 1950	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE Dec. 5, 1950		24C. NAME OF CEMETERY OR CREMATORY Jerusalem Lutheran Cem.	
24D. LOCATION (City, town, or county) Balto Md.		24E. FUNERAL DIRECTOR Lassahn Funeral Home		24F. ADDRESS 7401 Belair Rd.	

No. 1		No. 2		No. 3		No. 4		No. 5		No. 6		No. 7		No. 8		No. 9		No. 10		No. 11		No. 12		No. 13		No. 14		No. 15		No. 16		No. 17		No. 18		No. 19		No. 20		No. 21		No. 22		No. 23		No. 24		No. 25		No. 26		No. 27		No. 28		No. 29		No. 30		No. 31		No. 32		No. 33		No. 34		No. 35		No. 36		No. 37		No. 38		No. 39		No. 40		No. 41		No. 42		No. 43		No. 44		No. 45		No. 46		No. 47		No. 48		No. 49		No. 50		No. 51		No. 52		No. 53		No. 54		No. 55		No. 56		No. 57		No. 58		No. 59		No. 60		No. 61		No. 62		No. 63		No. 64		No. 65		No. 66		No. 67		No. 68		No. 69		No. 70		No. 71		No. 72		No. 73		No. 74		No. 75		No. 76		No. 77		No. 78		No. 79		No. 80		No. 81		No. 82		No. 83		No. 84		No. 85		No. 86		No. 87		No. 88		No. 89		No. 90		No. 91		No. 92		No. 93		No. 94		No. 95		No. 96		No. 97		No. 98		No. 99		No. 100		No. 101		No. 102		No. 103		No. 104		No. 105		No. 106		No. 107		No. 108		No. 109		No. 110		No. 111		No. 112		No. 113		No. 114		No. 115		No. 116		No. 117		No. 118		No. 119		No. 120		No. 121		No. 122		No. 123		No. 124		No. 125		No. 126		No. 127		No. 128		No. 129		No. 130		No. 131		No. 132		No. 133		No. 134		No. 135		No. 136		No. 137		No. 138		No. 139		No. 140		No. 141		No. 142		No. 143		No. 144		No. 145		No. 146		No. 147		No. 148		No. 149		No. 150		No. 151		No. 152		No. 153		No. 154		No. 155		No. 156		No. 157		No. 158		No. 159		No. 160		No. 161		No. 162		No. 163		No. 164		No. 165		No. 166		No. 167		No. 168		No. 169		No. 170		No. 171		No. 172		No. 173		No. 174		No. 175		No. 176		No. 177		No. 178		No. 179		No. 180		No. 181		No. 182		No. 183		No. 184		No. 185		No. 186		No. 187		No. 188		No. 189		No. 190		No. 191		No. 192		No. 193		No. 194		No. 195		No. 196		No. 197		No. 198		No. 199		No. 200		No. 201		No. 202		No. 203		No. 204		No. 205		No. 206		No. 207		No. 208		No. 209		No. 210		No. 211		No. 212		No. 213		No. 214		No. 215		No. 216		No. 217		No. 218		No. 219		No. 220		No. 221		No. 222		No. 223		No. 224		No. 225		No. 226		No. 227		No. 228		No. 229		No. 230		No. 231		No. 232		No. 233		No. 234		No. 235		No. 236		No. 237		No. 238		No. 239		No. 240		No. 241		No. 242		No. 243		No. 244		No. 245		No. 246		No. 247		No. 248		No. 249		No. 250		No. 251		No. 252		No. 253		No. 254		No. 255		No. 256		No. 257		No. 258		No. 259		No. 260		No. 261		No. 262		No. 263		No. 264		No. 265		No. 266		No. 267		No. 268		No. 269		No. 270		No. 271		No. 272		No. 273		No. 274		No. 275		No. 276		No. 277		No. 278		No. 279		No. 280		No. 281		No. 282		No. 283		No. 284		No. 285		No. 286		No. 287		No. 288		No. 289		No. 290		No. 291		No. 292		No. 293		No. 294		No. 295		No. 296		No. 297		No. 298		No. 299		No. 300		No. 301		No. 302		No. 303		No. 304		No. 305		No. 306		No. 307		No. 308		No. 309		No. 310		No. 311		No. 312		No. 313		No. 314		No. 315		No. 316		No. 317		No. 318		No. 319		No. 320		No. 321		No. 322		No. 323		No. 324		No. 325		No. 326		No. 327		No. 328		No. 329		No. 330		No. 331		No. 332		No. 333		No. 334		No. 335		No. 336		No. 337		No. 338		No. 339		No. 340		No. 341		No. 342		No. 343		No. 344		No. 345		No. 346		No. 347		No. 348		No. 349		No. 350		No. 351		No. 352		No. 353		No. 354		No. 355		No. 356		No. 357		No. 358		No. 359		No. 360		No. 361		No. 362		No. 363		No. 364		No. 365		No. 366		No. 367		No. 368		No. 369		No. 370		No. 371		No. 372		No. 373		No. 374		No. 375		No. 376		No. 377		No. 378		No. 379		No. 380		No. 381		No. 382		No. 383		No. 384		No. 385		No. 386		No. 387		No. 388		No. 389		No. 390		No. 391		No. 392		No. 393		No. 394		No. 395		No. 396		No. 397		No. 398		No. 399		No. 400		No. 401		No. 402		No. 403		No. 404		No. 405		No. 406		No. 407		No. 408		No. 409		No. 410		No. 411		No. 412		No. 413		No. 414		No. 415		No. 416		No. 417		No. 418		No. 419		No. 420		No. 421		No. 422		No. 423		No. 424		No. 425		No. 426		No. 42
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542

-10465

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10465

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

CLARENCE DANIELS

2. DATE
OF
DEATH

12-5-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

OKLAHOMA

V-33

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION

Singi Hospt.

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

TULSA

c. Length of stay in Baltimore

2 WEEKS

Yrs.
Mos.
Days

D. STREET ADDRESS (If rural, give location)

703 Mohawk BLVD

5. SEX

MALE

6. COLOR OR RACE

AMERICAN
INDIAN

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

MARRIED

8. DATE OF BIRTH

9. AGE (In years last birthday)

10 Under 1 Year Months: Days

11 Under 24 Hours Hours: Min.

55

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

NONE

10B. KIND OF BUSINESS OR INDUSTRY

NEVER WORKED

11. BIRTHPLACE (State or foreign country)

OKLAHOMA

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

NOT KNOWN

14. MOTHER'S MAIDEN NAME

NOT KNOWN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

HAZEL DANIELS - TULSA, OKLAHOMA

18. 420.0

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Uremia

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Chronic pyelonephritis

DUE TO

(C) Osteosclerotic heart disease

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from Nov. 27, 1950, to Dec. 5, 1950, that I last saw the deceased alive on Dec. 5, 1950, and that death occurred at 5:15 P.m., from the causes and on the date stated above.

23A. SIGNATURE

J. S. Smith

M. D.

23B. ADDRESS

Anai Hospital

23C. DATE SIGNED

Dec. 5, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify)

REMOVAL

24B. DATE

12/7/1950

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

TULSA, OKLAHOMA

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

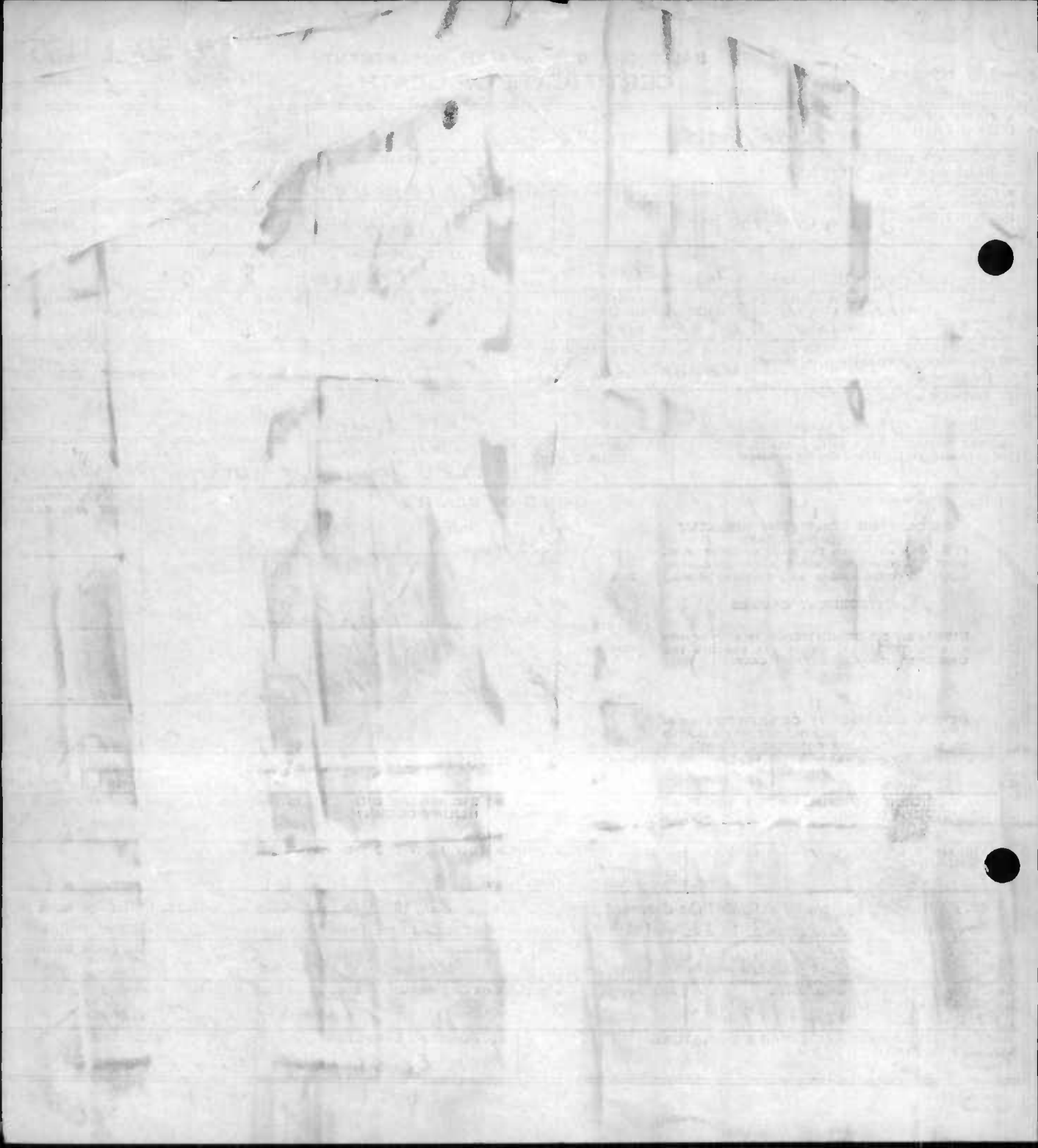
25. FUNERAL DIRECTOR

ADDRESS

DEC 7 - 1950

J. S. Smith

JACK LEWIS, Inc., 2100 EUTAW PL.



325
50-10466

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10466
Registered No.

1. NAME OF DECEASED (Type or Print) JOHN S. WATKINS		2. DATE OF DEATH Dec. 6, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION 2421 Harlem Ave.		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore	
C. Length of stay in Baltimore life		D. STREET ADDRESS (If rural, give location) 2421 Harlem Avenue	
5. SEX male	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) widowed	8. DATE OF BIRTH July 4, 1859
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Printer		10B. KIND OF BUSINESS OR INDUSTRY Newspaper	
13. FATHER'S NAME William F. A. Watkins		14. MOTHER'S MAIDEN NAME Ellen Poole	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) none		16. SOCIAL SECURITY NO.	
17. INFORMANT Miss Helen W. Watkins - 2421 Harlem Ave.		ADDRESS	

18. 4222 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Chronic Nephritis. (A) DUE TO		INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Chronic Myocarditis. (B) DUE TO		
Sclerosis. (C)		

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	
19A. DATE OF OPERATION none	19B. MAJOR FINDINGS OF OPERATION
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>
21F. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from **Sept 14, 1949** to **Dec. 6, 1950**, that I last saw the deceased alive on **Dec 3, 1950**, and that death occurred at **7 A. m.**, from the causes and on the date stated above.

23A. SIGNATURE George E. Shannon		23B. ADDRESS 820 Medical Arts Building		23C. DATE SIGNED Dec 6, 1950	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/9/50		24C. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cem.	
24D. LOCATION (City, town, or county) (State) Balto., Md.		25. FUNERAL DIRECTOR Wm. J. Sicker & Sons, Balto Md.		ADDRESS	
DATE RECEIVED BY LOCAL REGISTRAR DEC 7-1950		REGISTRAR'S SIGNATURE William F. A. Watkins		25. FUNERAL DIRECTOR Wm. J. Sicker & Sons, Balto Md.	

000001-00

250
50-10467BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10467

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Eddia Belle Brackum

2. DATE
OF
DEATH

12/5/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF
HOSPITAL OR
INSTITUTIONIf not in hospital or institution, give street address or location)
Hampnett Ave
Pine Ridge Nursing HomeYrs.
Mos.
Days

C. Length of stay in Baltimore

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

B. COUNTY

Md

C. CITY OR TOWN

Balto

D. STREET ADDRESS (If rural, give location)

5813 Bellona Ave

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years-
last birthday)If Under 1 Year
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, or if retired)10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Geo. E. Pfeiffer

14. MOTHER'S MAIDEN NAME

(Unknown) Bowersock

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

No

Catherine Moss 5813 Bellona Ave

18. 294X and 170X
DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATH

(A)

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e.g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

22. TIME (Month) (Day) (Year) (Hour)
INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT ☐ NOT WHILE ☐
WORK AT WORK22. I hereby certify that I attended the deceased from 1938, to 12/5, 1950, that I last saw the
deceased alive on 12/5, 1950, and that death occurred at 7:00 p.m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

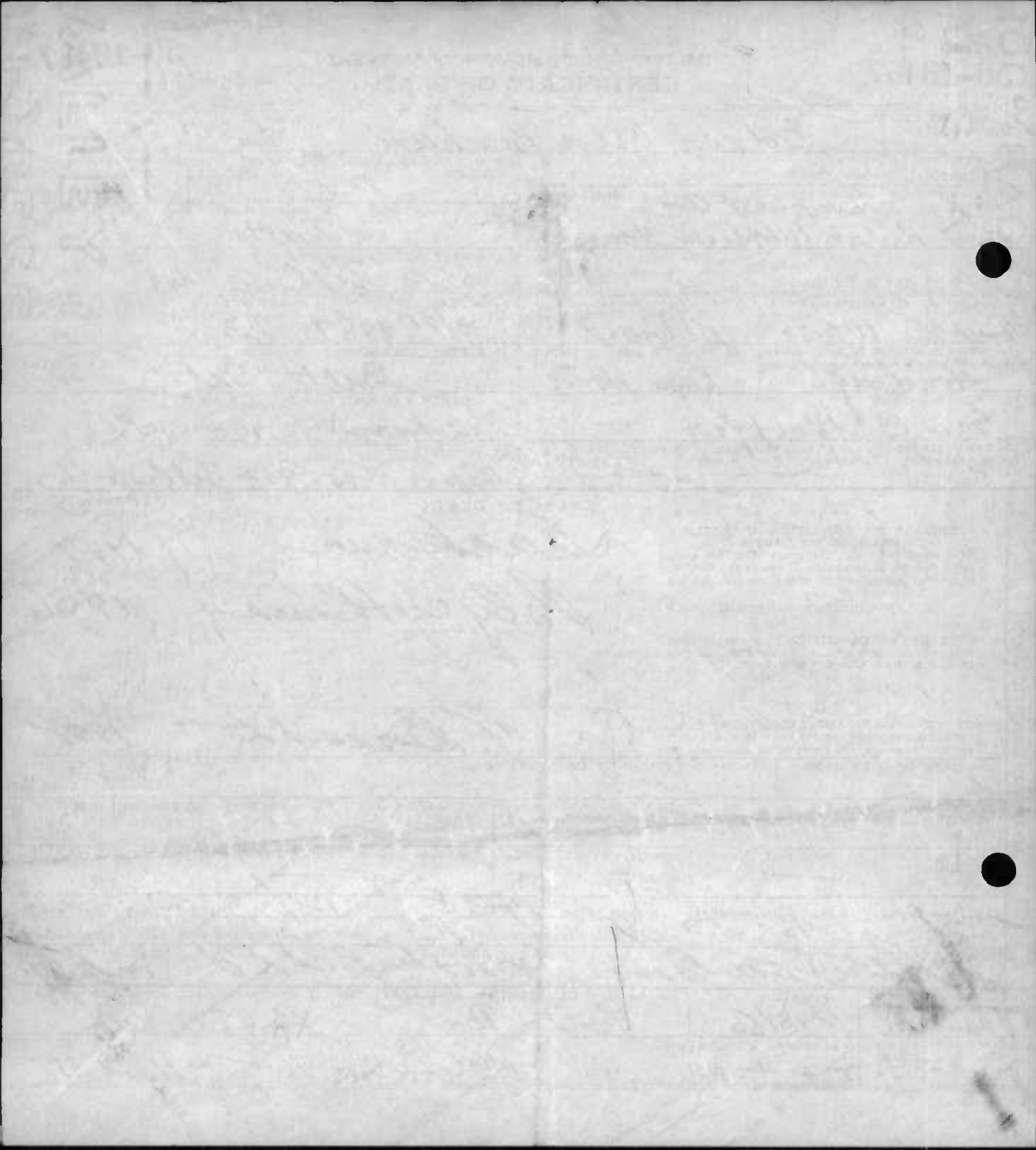
25. FUNERAL DIRECTOR

ADDRESS

DEC 7-1950

Huntington Williams, Md.

Wm Cook Inc. 1217 St. Paul St.



320

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10468

Registered No.

50-10468

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <i>Gladys M. Pautz</i>		2. DATE OF DEATH <i>12/6/50</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i>	
B. FULL NAME OF (If not in hospital or institution, give street address or location) <i>Maryland General Hospital</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore</i>	
c. Length of stay in Baltimore		D. STREET ADDRESS (If rural, give location) <i>605 Cathedral St. #1</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>white</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Single</i>	8. DATE OF BIRTH <i>July 29, 1892</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Deaconess</i>	10B. KIND OF BUSINESS OR INDUSTRY <i>Church</i>	9. AGE (In years last birthday) <i>58</i>	11. BIRTHPLACE (State or foreign country) <i>Kansas</i>
13. FATHER'S NAME <i>August R Pautz</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <i>no</i>	16. SOCIAL SECURITY NO.	14. MOTHER'S MAIDEN NAME <i>Jeanette Donaldson</i>	
17. INFORMANT <i>Mr. J. E. Kayser</i>		ADDRESS <i>605 Cathedral St.</i>	

18. *153X*

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) *Carcinomatosis of abdomen*

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) *Carcinoma of colon*

DUE TO

(C)

8 mo +

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

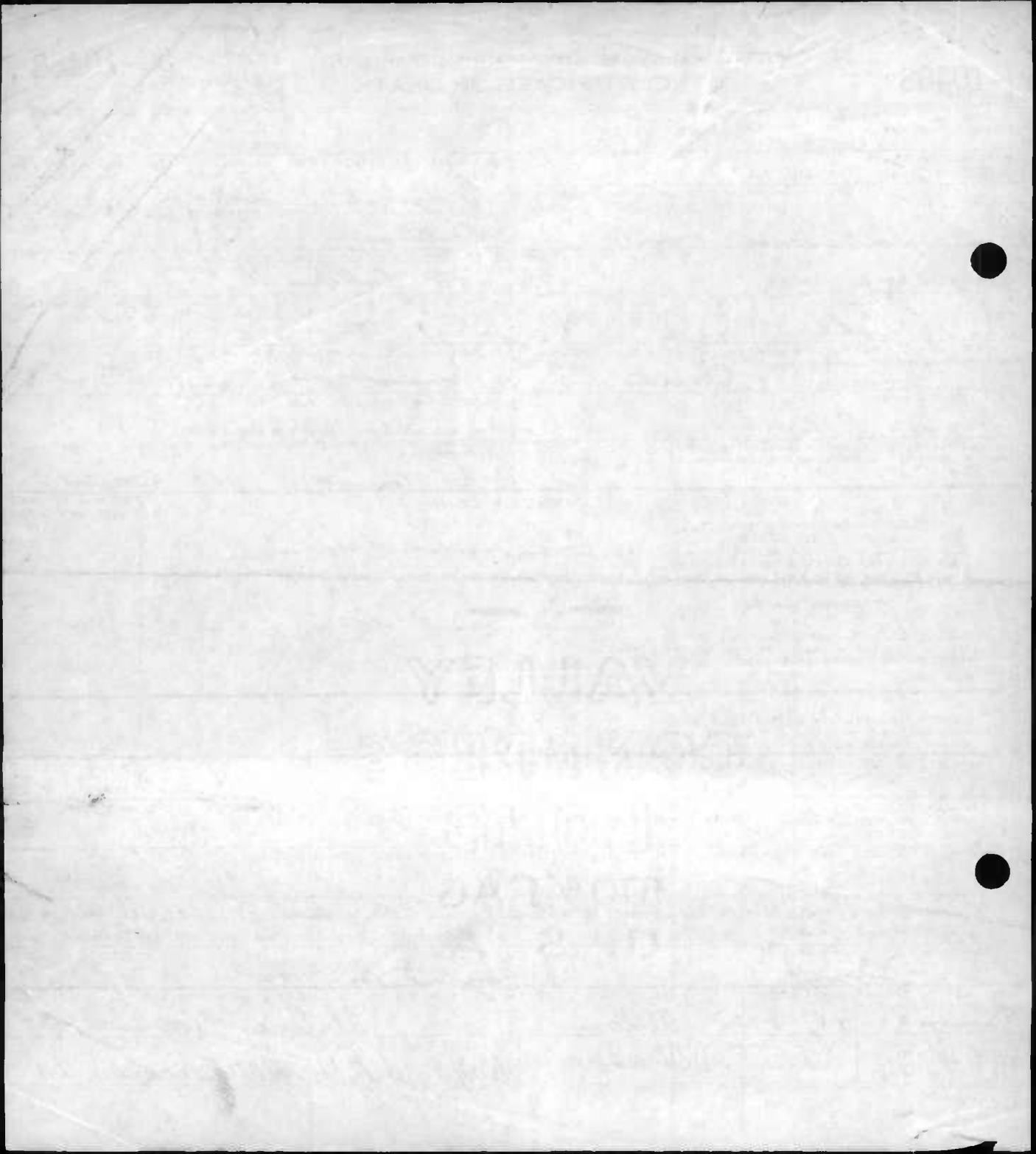
19A. DATE OF OPERATION <i>0</i>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>Nov 9</i> , 1950, to <i>Dec 6</i> , 1950, that I last saw the deceased alive on <i>Dec 6</i> , 1950, and that death occurred at <i>7:12 A.m.</i> , from the causes and on the date stated above.					
23A. SIGNATURE <i>G. E. Bryant</i>		23B. ADDRESS <i>M. O. Maryland Gen. Hosp.</i>		23C. DATE SIGNED <i>12/6/50</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>		24B. DATE <i>12.8.50</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Abilene</i>	
24D. LOCATION (City, town, or county) (State) <i>Abilene Kansas</i>		25. FUNERAL DIRECTOR <i>Henry Witzke 4101 Edmondson Ave.</i>			
DATE RECEIVED BY LOCAL REGISTRAR <i>DEC 7-1950</i>		REGISTRAR'S SIGNATURE <i>W. H. Williams, M.D.</i>		ADDRESS	

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46E

MEDICAL CERTIFICATION



254

50-10469

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10469

Registered No.

1. NAME OF DECEASED (Type or Print) HARRY C. McNEILL		2. DATE OF DEATH Dec. 6, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) A. STATE MD. B. COUNTY 27-01	
B. FULL NAME OF (If not in hospital or institution, give street address or location) 2805 Pinewood		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTO.	
c. Length of stay in Baltimore LIFE		D. STREET ADDRESS (If rural, give location) 2805 Pinewood Ave	
5. SEX M.	6. COLOR OR RACE W.	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) MARRIED.	8. DATE OF BIRTH 5/17/27
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shipping Clerk - CLOTHING MFG.		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 73
13. FATHER'S NAME John McNeill		11. BIRTHPLACE (State or foreign country) BALTIMORE	12. CITIZEN OF WHAT COUNTRY? U.S.A.
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NO		16. SOCIAL SECURITY NO. 214-03-5226	17. INFORMANT ADDRESS Mrs Anna McNeill

18. 443 X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Hypertensive Cardio Vascular Disease		INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (A) DUE TO (B) DUE TO (C) DUE TO		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION 0		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Jan 1, 1950 to 12/6, 1950 , that I last saw the deceased alive on Jan 1, 1950 , and that death occurred at 52 m., from the causes and on the date stated above.					
23A. SIGNATURE W. W. Galloway		23B. ADDRESS 5103 Parkwood Rd		23C. DATE SIGNED 12/7/50	
24A. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 12/9/50		24C. NAME OF CEMETERY OR CREMATORY PARKWOOD	
24D. LOCATION (City, town, or county) TAYLOR AVE		24E. (State) MD		25. FUNERAL DIRECTOR ADDRESS Mildred J. Blight, 6009 Highland	
DATE RECEIVED BY LOCAL REGISTRAR DEC 7 - 1950		REGISTRAR'S SIGNATURE William Williams, M.D.		25. FUNERAL DIRECTOR ADDRESS Mildred J. Blight, 6009 Highland	

VS 150

342 4G

93D (14)

MEDICAL CERTIFICATION

Geo. K. W. Salling

**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

50-10470
Registered No.

BIRTH NO. 50-18761

1. NAME OF DECEASED (Type or Print) EARL L. (STEEFMAN) SPEARMAN			2. DATE OF DEATH Dec. 6, 1950		
3. PLACE OF DEATH: A. Baltimore City, Maryland Balto. city			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY		
B. FULL NAME OF HOSPITAL OR INSTITUTION Johns Hopkins Hospital			C. CITY OR TOWN (If outside corporate limits write RURAL and give township) Baltimore		
D. STREET ADDRESS (If rural, give location) 503 N. Patterson Park Ave.			E. LENGTH OF STAY IN BALTIMORE Life Yrs. Mos. Days		
5. SEX Male	6. COLOR OR RACE Colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH Sept. 6 - 1910		9. AGE (In years last birthday) 3 Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10B. KIND OF BUSINESS OR INDUSTRY none	11. BIRTHPLACE (State or foreign country) Baltimore md		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Thomas Spearman			14. MOTHER'S MAIDEN NAME Ella Ball		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.	17. INFORMANT Thomas Spearman ADDRESS 503 N.		

18. 492X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Interstitia Pneumonitis DUE TO		INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED m. WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	

22. I certify that I took charge of the remains described above, held an **Autopsy** thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE Stanley S. Shulaker M.D.		23B. CHIEF MEDICAL EXAMINER..... <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER..... <input type="checkbox"/> MEDICAL INVESTIGATOR..... <input type="checkbox"/>		23C. DATE SIGNED Dec. 6, 1950	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial	24B. DATE 12-8-50	24C. NAME OF CEMETERY OR CREMATORY mt clemens		24D. LOCATION (City, town, or county) (State) Brooklyn md	
DATE RECEIVED BY LOCAL REGISTRAR DEC 7 - 1950	REGISTRAR'S SIGNATURE Huntington Williams	25. FUNERAL DIRECTOR Chas. O. Wilson		ADDRESS 1100 Brantley	

50-101-05

DEATH CERTIFICATE

635 15
0-10471
BIRTH NO. 50-15809

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10471
Registered No.

1. NAME OF DECEASED (Type or Print) PHYLLIS MARTIN			2. DATE OF DEATH December 3, 1950		
3. PLACE OF DEATH: A. Baltimore City, Maryland Balto. city			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 3-01		
B. FULL NAME OF HOSPITAL OR INSTITUTION Baltimore City Hospital			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore		
D. STREET ADDRESS (If rural, give location) 507 S. Caroline Street					
5. LENGTH OF STAY IN BALTIMORE Life			Yrs. Life Mos. Life Days Life		
5. SEX Female	6. COLOR OR RACE Colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH Aug. 3-1950	9. AGE (In years last birthday) 4	10. Under 1 Year Months: Days 4
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none			10B. KIND OF BUSINESS OR INDUSTRY none		
11. BIRTHPLACE (State or foreign country) Baltimore Md			12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME Lawrence Martin			14. MOTHER'S MAIDEN NAME Thelma Brown		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no			16. SOCIAL SECURITY NO.		
17. INFORMANT Thelma Martin 507 S. Caroline St			ADDRESS		

18. E 983 X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Subdural hemorrhage DUE TO Multiple contusions of scalp		INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION Nov. 30, 1950		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/> UNDERLYING <input type="checkbox"/> CONTRIBUTING		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) Home		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 507 S. Caroline Street	
21D. TIME (Month) (Day) (Year) (Hour) Nov. 30, 1950		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? Struck on head with nursing bottle	
22. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input checked="" type="checkbox"/> , undetermined <input type="checkbox"/> .					
23A. SIGNATURE William V. Smith		23B. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> M.D. MEDICAL INVESTIGATOR		23C. DATE SIGNED Dec. 6, 1950	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-7-50		24C. NAME OF CEMETERY OR CREMATORY mt Calvary Cem. Brooklyn Md	
24D. LOCATION (City, town, or county) (State) Baltimore Md		24E. FUNERAL DIRECTOR Choy S. Wilson, 1000 Brantley		24F. ADDRESS	

10401-6

STATE OF TEXAS
COUNTY OF DALLAS

7



430

50-10472

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10472

Registered No.

1. NAME OF DECEASED (Type or Print) <i>Michael Geleta</i>		2. DATE OF DEATH <i>12/6/50</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <i>Baltimore Maryland</i>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i>	
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>South Baltimore General Hospital</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore</i>	
C. Length of stay in Baltimore <i>38 yrs</i>		D. STREET ADDRESS (If rural, give location) <i>1516 Aliceanna Street</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Married</i>	8. DATE OF BIRTH <i>Sept. 22 1891</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Stevadore</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Longshoreman</i>	9. AGE (in years last birthday) <i>59</i>
11. BIRTHPLACE (State or foreign country) <i>Poland</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Matthew Geleta</i>		14. MOTHER'S MAIDEN NAME <i>Rozalia Bandorz</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>215-05-3351</i>	17. INFORMANT ADDRESS <i>Kazmiera Geleta 1516 Aliceanna Street</i>
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <i>Acute Gangrenous Cholecystitis</i>		INTERVAL BETWEEN ONSET AND DEATH <i>14 days</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <i>Cerebral Vascular Accident</i>			
19A. DATE OF OPERATION <i>Nov. 27, 1950</i>		19B. MAJOR FINDINGS OF OPERATION <i>Gangrenous Gall. Bladder</i>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>11/26</i> , 1950, to <i>12/6</i> , 1950, that I last saw the deceased alive on <i>12/6</i> , 1950, and that death occurred at <i>5:45 A.M.</i> , from the causes and on the date stated above.			
23A. SIGNATURE <i>Calvin Y. Hadidian</i>		23B. ADDRESS <i>1213 Light Street</i>	
23C. DATE SIGNED <i>12/6/50</i>			
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>Dec. 9-1950</i>	
24C. NAME OF CEMETERY <i>St. Stanislaus</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>	
DATE RECEIVED BY LOCAL REGISTRAR <i>DEC 7-1950</i>		REGISTRAR'S SIGNATURE <i>Thurston Williams, M.D.</i>	
25. FUNERAL DIRECTOR <i>George A. Weber</i>		ADDRESS <i>705 S. Penn St</i>	

MEDICAL CERTIFICATION

94055

127B

**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

50-10473

Registered No.

636
REA-139494
BIRTH NO. 10473

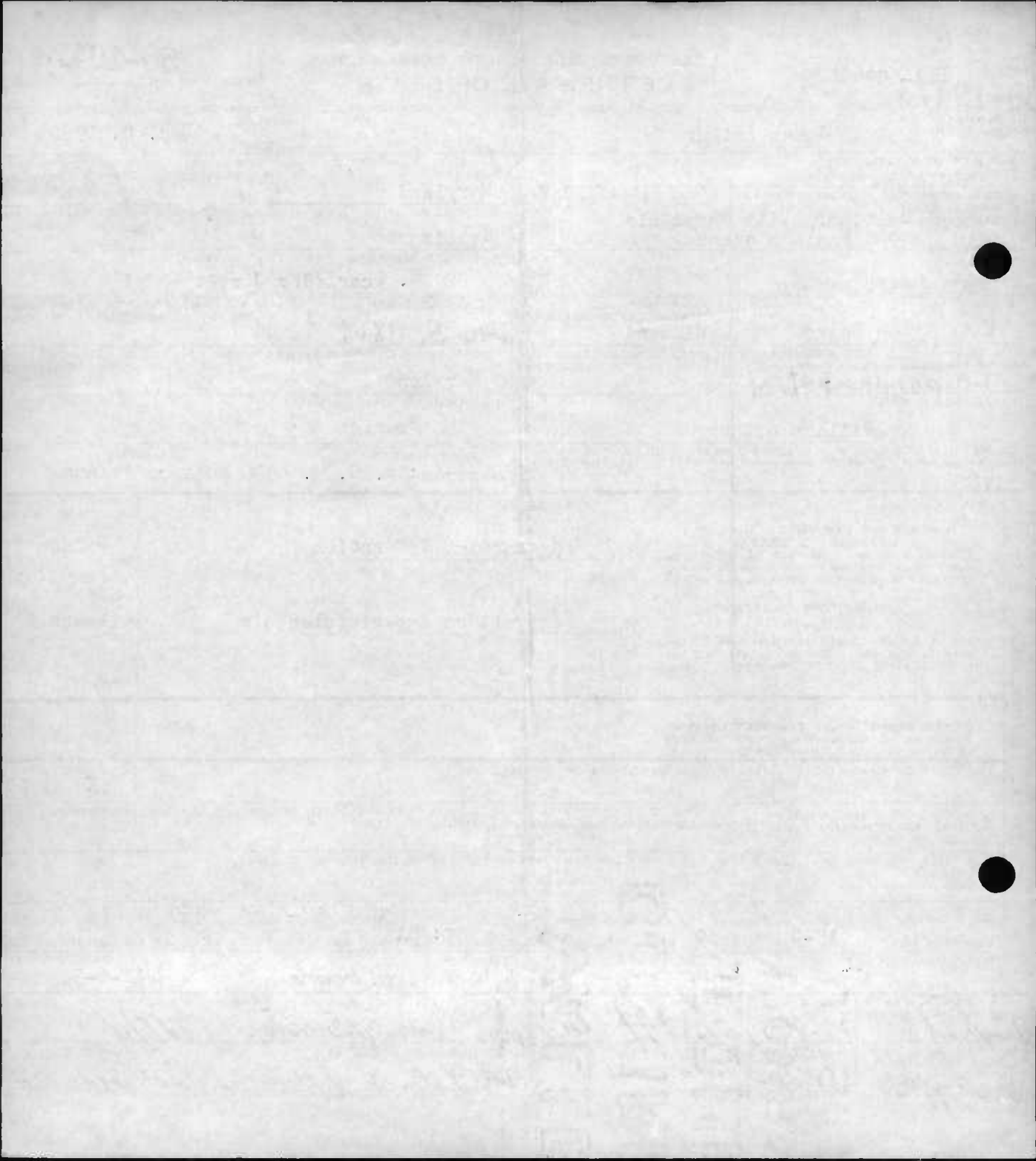
1. NAME OF DECEASED (Type or Print) James Arthur			2. DATE OF DEATH Dec. 4, 1950		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 18-21		
B. FULL NAME OF (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Avenue			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore		
c. Length of stay in Baltimore Life			D. STREET ADDRESS (If rural, give location) 229 N. Schroeder Street		
5. SEX Male	6. COLOR OR RACE Negro	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Dec. 5, 1869		9. AGE (In years last birthday) 80
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer - Refined			11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? ?
13. FATHER'S NAME William Arthur			14. MOTHER'S MAIDEN NAME Frances ?		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS Records: B. C. H. 4940 Eastern Avenue		

18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Myocardial Infarction (A) DUE TO		INTERVAL BETWEEN ONSET AND DEATH Sudden Years
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Generalized Arteriosclerosis (B) DUE TO		
(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION 2		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 7-6 , 1950, to 12-4 , 1950, that I last saw the deceased alive on 12-4 , 1950, and that death occurred at 5:20A m., from the causes and on the date stated above.				
23A. SIGNATURE <i>[Signature]</i> M. D.		23B. ADDRESS 4940 Eastern Avenue		23C. DATE SIGNED 12-6-50

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial	24B. DATE 12-8-1950	24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem. Balto.	24D. LOCATION (City, town, or county) (State) Ma.
DATE RECEIVED BY LOCAL REGISTRAR DEC 7 - 1950	REGISTRAR'S SIGNATURE <i>[Signature]</i>		25. FUNERAL DIRECTOR Mrs. Katie R. Williams
			ADDRESS Schroeder St.

MEDICAL CERTIFICATION



420
50-10474

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50-10474

1. NAME OF DECEASED (Type or Print) GRACE BELL MILLS			2. DATE OF DEATH December 4, 1950		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY		
B. FULL NAME OF (If not in hospital or institution, give street address or location) University Hospital			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore		
D. STREET ADDRESS (If rural, give location) 2658 Flora Street			E. LENGTH OF STAY IN BALTIMORE Yrs. Mos. Days		
5. SEX Female	6. COLOR OR RACE Colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH July 22, 1900	9. AGE (In years last birthday) 50	10. Under 1 Year Months Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10B. KIND OF BUSINESS OR INDUSTRY		
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Jefferson Webb			14. MOTHER'S MAIDEN NAME Maggie Robinson		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO.		
17. INFORMANT George Mills			ADDRESS 2658 Flora Street		

18. 443X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Hypertensive cardiovascular disease (A) DUE TO ANTECEDENT CAUSES (B) DUE TO (C) DUE TO OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		INTERVAL BETWEEN ONSET AND DEATH
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19A. DATE OF OPERATION 0		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		

22. I certify that I took charge of the remains described above, held an Insp. & Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE William V. [Signature]		23B. CHIEF MEDICAL EXAMINER..... ASSISTANT MEDICAL EXAMINER..... MEDICAL INVESTIGATOR.....		23C. DATE SIGNED 12-4-50
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial	24B. DATE 12-7-1950	24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem Balto.	24D. LOCATION (City, town, or county) (State) Md.	
DATE RECEIVED BY LOCAL REGISTRAR DEC 7-1950	REGISTRAR'S SIGNATURE [Signature]	25. FUNERAL DIRECTOR Mrs. Katie R. Williams		ADDRESS 3221 Schroeder St 935V

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50-10475

651
50-10475
BIRTH NO.

1. NAME OF DECEASED (Type or Print) GEORGE C. GRANVILLE			2. DATE OF DEATH 12-5-50		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Baltimore		
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION SINAI Hosp -			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Middle River		
c. Length of stay in Baltimore Yrs. Mos. Days			D. STREET ADDRESS (If rural, give location) 512 Middle River Rd. 5300		
5. SEX M	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH Mch. 10, 1903	9. AGE (In years last birthday) 47	10. Under 1 Year Months Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer Retired			10B. KIND OF BUSINESS OR INDUSTRY Home Laundry		
11. BIRTHPLACE (State or foreign country) Baltimore			12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME Henry			14. MOTHER'S MAIDEN NAME Elizabeth Knoble		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. 212-048263		
17. INFORMANT Eleanora Granville			ADDRESS Rd. 512 Middle River		

18. 420.0 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Myocardial infarct DUE TO Anterior left heart disease DUE TO Other significant conditions contributing to the death, but not related to the disease or condition causing it.		INTERVAL BETWEEN ONSET AND DEATH
19A. DATE OF OPERATION 2		19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		

MEDICAL CERTIFICATION

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED m. WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **12-1-1950** to **12-5-1950**, that I last saw the deceased alive on **12-5-1950**, and that death occurred at **1:30 A.M.**, from the causes and on the date stated above.

23A. SIGNATURE **Henry C. Stetson** M. D. 23B. ADDRESS **Seneca Hosp. Balt. Md.** 23C. DATE SIGNED **12-5-50**

24A. BURIAL, CREMATION, REMOVAL (Specify) **Burial** 24B. DATE **12/8/50** 24C. NAME OF CEMETERY OR CREMATORY **Oak Lawn** 24D. LOCATION (City, town, or county) (State) **Baltimore**

DATE RECEIVED BY LOCAL REGISTRAR **DEC 7-1950** REGISTRAR'S SIGNATURE **Augustine Williams, M.D.** 25. FUNERAL DIRECTOR **Blair F. Hoffman** ADDRESS **1639 Broadway**

9708C

93D

DEPARTMENT OF HEALTH

OFFICE OF THE STATE COMMISSIONER OF HEALTH

NEW YORK, N. Y.

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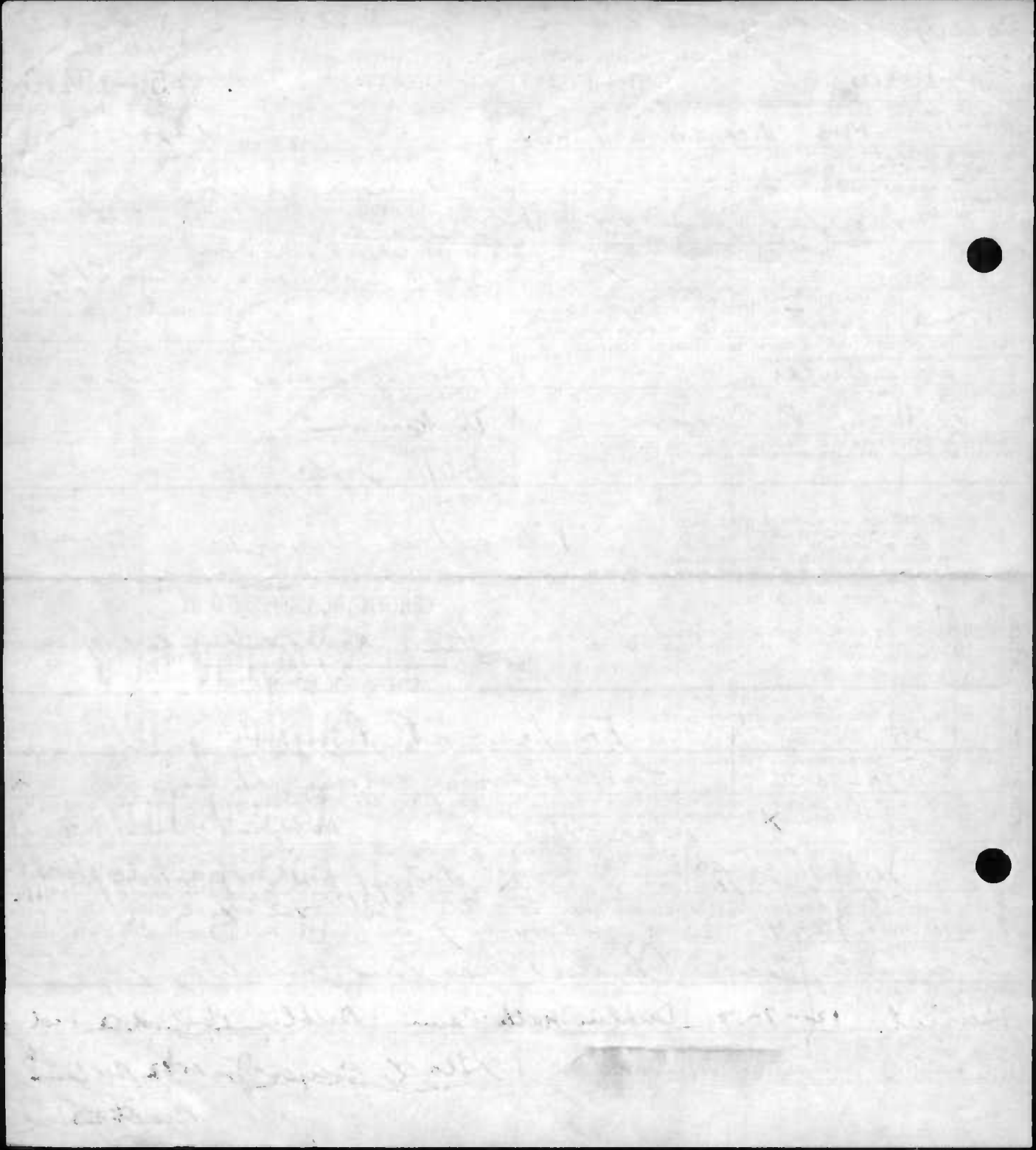
1917

1917

1. NAME OF DECEASED (Type or Print) Mrs Roxanna Anderson			2. DATE OF DEATH 12/4/50		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived, If institution, residence before admission) A. STATE Baltimore Maryland B. COUNTY Baltimore		
5. FULL NAME OF HOSPITAL OR INSTITUTION Maryland General Hospital			6. CITY OR TOWN Baltimore		
7. Length of stay in Baltimore 70 Yrs. Mos. Days			8. STREET ADDRESS (If rural, give location) 3214 Woodhome Avenue #14		
9. SEX Female	10. COLOR OR RACE white	11. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) widowed	12. DATE OF BIRTH 11/3/1875	13. AGE (In years last birthday) 75	14. Under 1 Year Months Days
15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			16. KIND OF BUSINESS OR INDUSTRY		
17. FATHER'S NAME William P Cooper			18. MOTHER'S MAIDEN NAME Unknown		
19. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)			20. SOCIAL SECURITY NO.		
21. INFORMANT Edith Dobbs			22. ADDRESS as above		

23. 010X and E 903.7 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	24. CAUSE OF DEATH (A) Tuberculous meningitis DUE TO	25. INTERVAL BETWEEN ONSET AND DEATH 3 mos +
26. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	27. CERTIFICATION APPROVED BY (B) Stanley K. Dunleavy M. D. DUE TO (C) CHIEF OR ASST. MEDICAL EXAMINER.	

28. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Fracture - nt femur			29. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
30. DATE OF OPERATION 10-28-50	31. MAJOR FINDINGS OF OPERATION Smith-Peterson nailing nt hip			32. DATE OF DEATH 12-4-50	
33. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH	34. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office, etc.) in hospital	35. WHERE DID INJURY OCCUR? in Baltimore City, give exact location, Maryland General Hospital	36. HOW DID INJURY OCCUR? Patient fell attempting to walk		
37. TIME (Month) (Day) (Year) (Hour) 10/18/50 7:50 AM	38. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	39. I hereby certify that I attended the deceased from 8-30 1950 to 12-4 1950 and that death occurred at 9 PM., from the causes and on the date stated above.			
40. SIGNATURE McQuinn, Lucius C.	41. ADDRESS Maryland General Hospital	42. DATE SIGNED 12/4			
43. BURIAL, CREMATION, REMOVAL (Specify) Burial	44. DATE 12-7-50	45. NAME OF CEMETERY OR CREMATORY Dublin Meth. Cem	46. LOCATION (City, town, or county) (State) Dublin Harford Co Md		
47. DATE RECEIVED BY LOCAL REGISTRAR DEC 7 - 1950	48. REGISTRAR'S SIGNATURE Huntington Williams, M.D.	49. FUNERAL DIRECTOR ADDRESS Geo E. Beyer Jr 1572 Hollins 186a Balt 23rd			



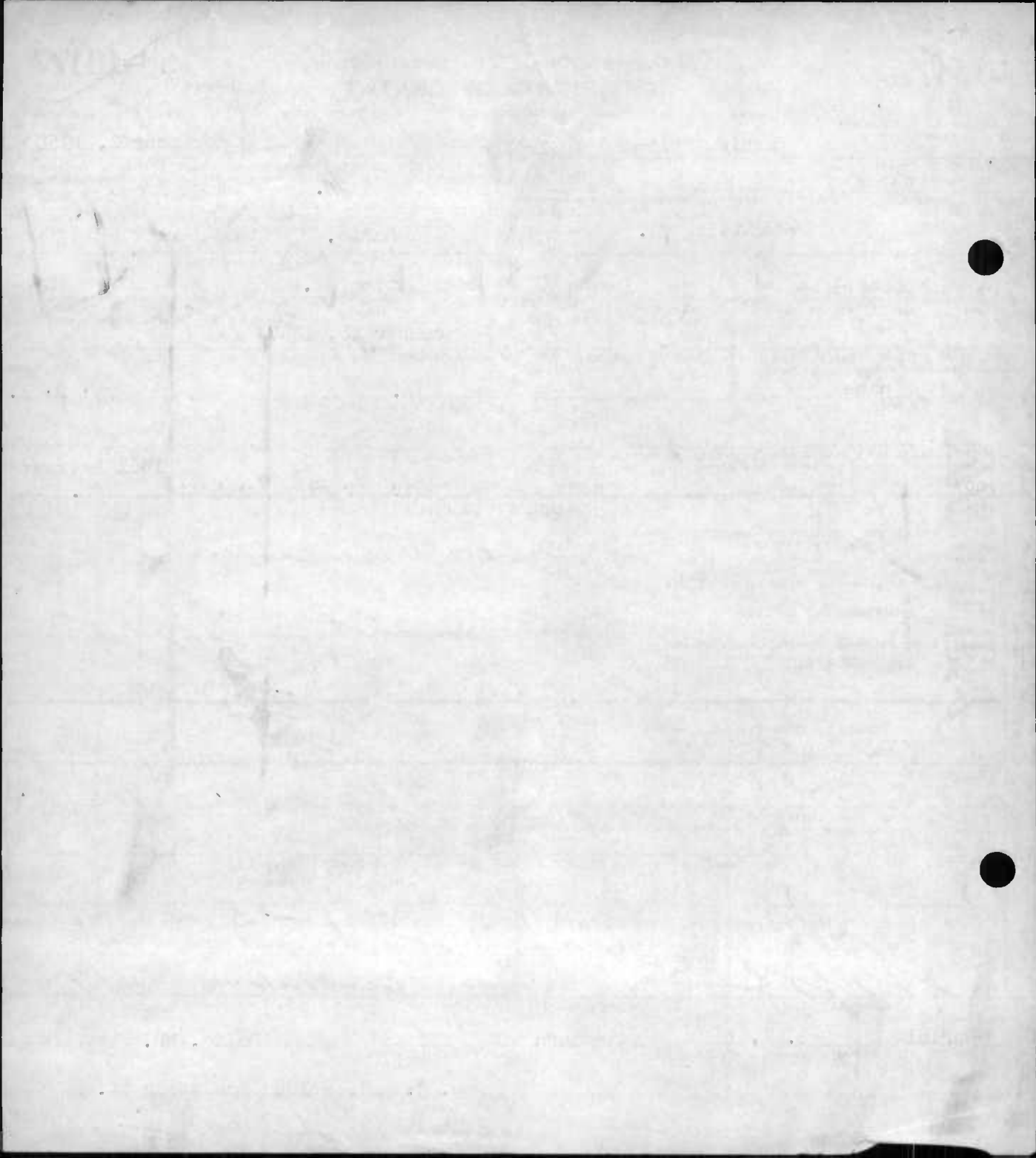
520
463
50-10477

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10477
Registered No.

1. NAME OF DECEASED (Type or Print) Fannie (Haines) Woolridge		2. DATE OF DEATH December 3, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION 2429 Etting St.		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto.	
C. Length of stay in Baltimore ? Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) 2429 Etting St.	
5. SEX F	6. COLOR OR RACE C	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) W	8. DATE OF BIRTH December 25, 1857 9. AGE (in years last birthday) 92
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Va.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME ?		14. MOTHER'S MAIDEN NAME ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Alice Crawley Prichett		ADDRESS 1601 Retreat St.	
18. 442X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Cardio Vascular Renal DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Serility DUE TO OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION 0		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME (Month) (Day) (Year) (Hour) INJURY	
21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 11-30 , 19 50 , to 12-3 , 19 50 , that I last saw the deceased alive on 11-30 , 19 50 , and that death occurred at 2P m., from the causes and on the date stated above.			
23A. SIGNATURE [Signature] M. D.		23B. ADDRESS 2033 Presstman St.	
23C. DATE SIGNED 12/5/50			
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE Dec. 7, 1950	
24C. NAME OF CEMETERY OR CREMATORY Mt Auburn		24D. LOCATION (City, town, or county) (State) Balto. Md.	
DATE RECEIVED BY LOCAL REGISTRAR 12-7-50		REGISTRAR'S SIGNATURE [Signature]	
25. FUNERAL DIRECTOR Geo. G. Kelson		ADDRESS 1303 Presstman St.	

[Signature] 131a



655
50-10478BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10478

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Lena R. Freeman

2. DATE
OF
DEATH

Dec 5 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF
HOSPITAL OR
INSTITUTION (If not in hospital or institution, give street address or
location)

1607 N. Carey St

C. Length of stay in Baltimore

Life

Yrs.
Mos.
Days4. USUAL RESIDENCE (Where deceased lived. If institution: residence
before admission)

A. STATE

B. COUNTY

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give
township)

D. STREET ADDRESS (If rural, give location)

1607 N. Carey St

5. SEX

F

6. COLOR OR RACE

C

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

m

10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

House wife

10B. KIND OF BUSINESS OR
INDUSTRY

13. FATHER'S NAME

Eli Handesty

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

8. DATE OF BIRTH

July 18, 1889

9. AGE (in years
last birthday)

61

If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.

11. BIRTHPLACE (State or foreign country)

ind

12. CITIZEN OF
WHAT COUNTRY?

U. S. A

14. MOTHER'S MAIDEN NAME

Eliza Forbs

17. INFORMANT

ADDRESS

Hattie Freeman 1607 N. Carey St

18. 420.1 I

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

CAUSE OF DEATH

(A)

DUE TO

Coronary Arteriosclerosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT

NOT WHILE

m.

WORK ☐AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov 20, 1950, to Dec 5, 1950, that I last saw the
deceased alive on 12-5-50, and that death occurred at m., from the causes and on the date stated above.

23A. SIGNATURE

M. D.

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY
LOCAL REGISTRAR

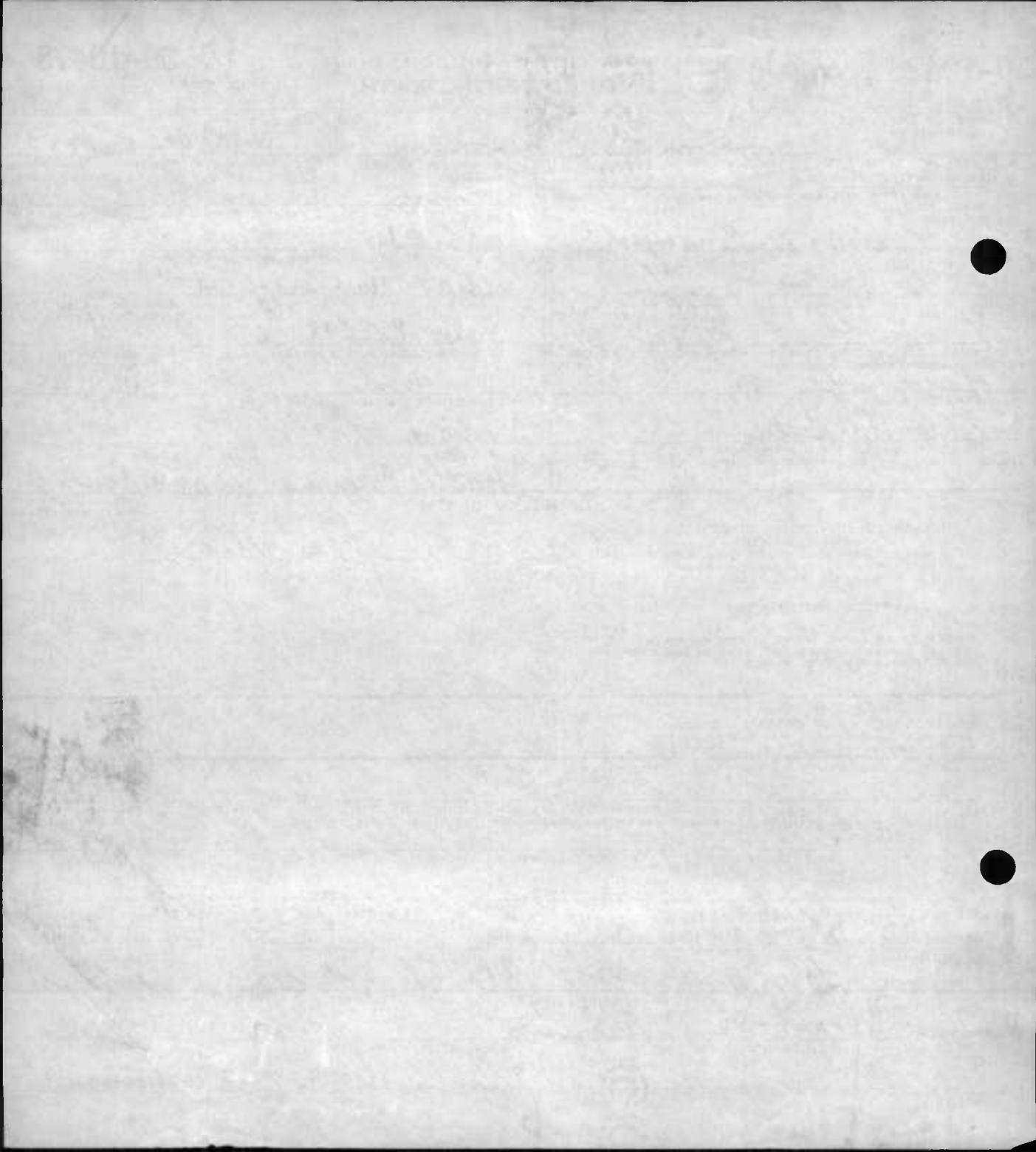
REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

12-7-50

Geo B. Helmer 1303 Prentissman St



525
50-10479

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10479

Registered No. _____

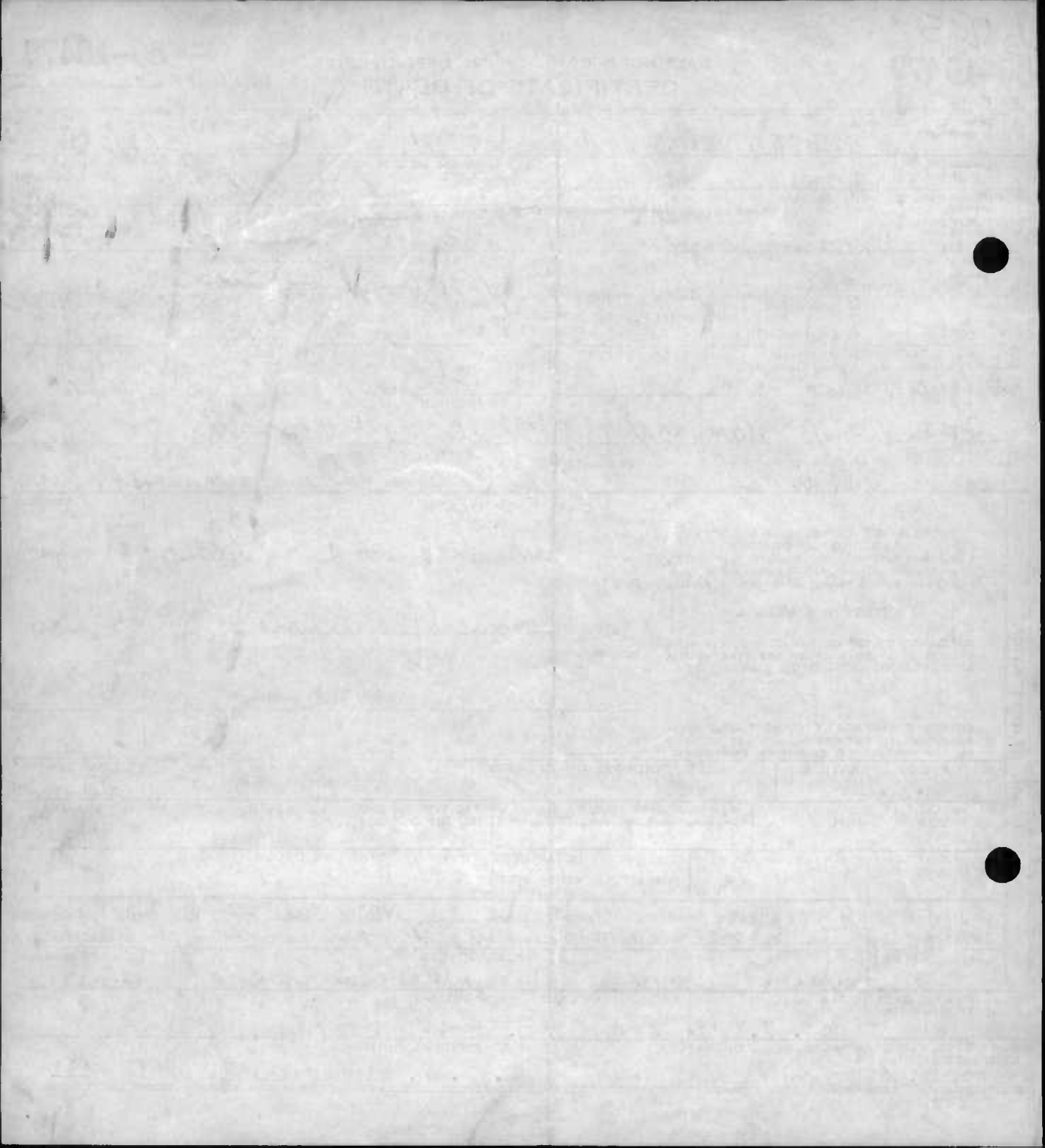
1. NAME OF DECEASED (Type or Print) RICHARD GRAFTON JOHNSON		2. DATE OF DEATH 12/2/50	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore City	
B. FULL NAME OF HOSPITAL OR INSTITUTION 1 Scovident Hospital		C. CITY OR TOWN (If outside corporate limits, give RURAL and give township) Baltimore	
c. Length of stay in Baltimore Life		D. STREET ADDRESS (If rural, give location) 1651 Druid Hill Ave	
5. SEX Male	6. COLOR OR RACE Negro	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH Feb. 11, 1895
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) post office - relief clerk		11. BIRTHPLACE (State or foreign country) Baltimore Maryland	
13. FATHER'S NAME GEORGE D. JOHNSON		14. MOTHER'S MAIDEN NAME CORA E. GIBSON	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) yes	16. SOCIAL SECURITY NO. World War I	17. INFORMANT ADDRESS Mrs. George Holland 1651 Druid Hill Ave	
48. 4/20.1		CAUSE OF DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) acute myocardial infarction	
ANTECEDENT CAUSES		(B) coronary sclerosis	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		INTERVAL BETWEEN ONSET AND DEATH 28 days 4 years	
19A. DATE OF OPERATION 0		19B. MAJOR FINDINGS OF OPERATION	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) no		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I hereby certify that I attended the deceased from Dec. 3, 1946 , to Dec 3, 1950 , that I last saw the deceased alive on Dec 3, 1950 , and that death occurred at 2:30 p. m. , from the causes and on the date stated above.	
23A. SIGNATURE James D. Carr		23B. ADDRESS 1437 Madison Ave	
23C. DATE SIGNED 12.4.50		24A. BURIAL, CREMATION, REMOVAL (Specify) Burial	
24B. DATE Dec. 7, 1950		24C. NAME OF CEMETERY OR CREMATORY Arbutus Mem. Park	
24D. LOCATION (City, town, or county) (State) Arbutus, Maryland		25. FUNERAL DIRECTOR ADDRESS J. L. P. Linbercy-1631 Druid Hill	
DATE RECEIVED BY LOCAL REGISTRAR DEC 7-1950		REGISTRAR'S SIGNATURE W. L. Williams	

MEDICAL CERTIFICATION

VS 150

39190

94a Ave.



BALTIMORE CITY HEALTH DEPARTMENT

50-10480

50-10480

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Helen P. Boyce (Mrs. William Wheeler)

2. DATE
OF
DEATH

Dec. 6, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

Baltimore

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION

Union Memorial Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Lutherville

D. STREET ADDRESS (If rural, give location)

Seminary Avenue 5300

C. Length of stay in Baltimore

Yrs.
Mos.
4 Days

5. SEX

Female

6. COLOR OR RACE

white

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

August 27, 1896

9. AGE (In years
last birthday)

54

If Under 1 Year
Months DaysIf Under 24 Hours
Hours Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

None

10B. KIND OF BUSINESS OR
INDUSTRY

At Home

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Jesse Powder

14. MOTHER'S MAIDEN NAME

Clara Hunter

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

None

16. SOCIAL
SECURITY NO.

None

17. INFORMANT

ADDRESS

W. Wheeler Boyce Lutherville, Md.

18. 420.1 I CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A)

DUE TO

Carmory Reclusion

INTERVAL BETWEEN
ONSET AND DEATH

3 da.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m.

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐22. I hereby certify that I attended the deceased from Dec. 3, 1950, to Dec. 6, 1950, that I last saw the
deceased alive on Dec. 6, 1950, and that death occurred at 5:30 p.m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

Alvin Bonzlaac

M. D.

Union Memorial Hosp.

12-6-50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

BURIAL

DEC. 8, 1950

DRUIDRIDGE CEM.

PIRESVILLE, MD.

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

DEC 7 - 1950

Huntington Williams, M.D.

JOHN BURN'S' SONS, TOWSON, MD.

02101-06

02101-06



425
0-10481

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10481

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Alice S. Mullican

2. DATE OF DEATH
December 6, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
721 McHenry Street

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)
A. STATE Maryland B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore

D. STREET ADDRESS (If rural, give location)
721 McHenry Street

c. Length of stay in Baltimore
Yrs. Mos. Days

5. SEX female 6. COLOR OR RACE white 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) widowed

8. DATE OF BIRTH March 11, 1869 9. AGE (in years last birthday) 81 If Under 1 Year Months: Days If Under 24 Hours Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife 10B. KIND OF BUSINESS OR INDUSTRY own home

11. BIRTHPLACE (State or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME John D. Greager

14. MOTHER'S MAIDEN NAME Matilda C. Roberts

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) 16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS Mrs. Goldie Shaff, 721 McHenry Street

18. 443X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH Cardiac Compensation 11/1-56
(A) DUE TO
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) Pulmonary Edema 11/28-50
(C) Due TO Hypertension Arterial Sclerosis
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION 19B. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? YES NO

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY 21E. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11/1 1950 to 12/6 1950, that I last saw the deceased alive on 12/4 1950 and that death occurred at 3:15 P.m., from the causes and on the date stated above.

23A. SIGNATURE Charles W. Cook 23B. ADDRESS 2145 N. Baltimore St. 23C. DATE SIGNED 12/7-50

24A. BURIAL, CREMATION, REMOVAL (Specify) burial 24B. DATE 12/8/50 24C. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery 24D. LOCATION (City, town, or county) (State) Frederick, Maryland

DATE RECEIVED BY LOCAL REGISTRAR DEC 7 - 1950 REGISTRAR'S SIGNATURE Huntington Williams, M.D. 25. FUNERAL DIRECTOR 24m. Cook, Inc. ADDRESS 1217 St. Paul Street

18101-08

520
50-10482BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10482

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

EVA M. LANGE

2. DATE
OF
DEATH

12/6/50

3. PLACE OF DEATH:

a. Baltimore City, Maryland

b. FULL NAME OF
HOSPITAL OR
INSTITUTION (If not in hospital or institution, give street address or location)

UNIVERSITY HOSPITAL

48 Yrs.
Moa
Days

c. Length of stay in Baltimore

5. SEX
F6. COLOR OR RACE
W7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

MARRIED

10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR
INDUSTRY

H.W.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence
a. STATE b. COUNTY before admission)

MARYLAND

BALTIMORE

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

BALTIMORE

14

d. STREET ADDRESS (If rural, give location)

3033 LINWOOD AVE.

8. DATE OF BIRTH

1902-4-27

9. AGE (in years
last birthday)

48

11 Under 1 Year
Months Days Hours Min.

11. BIRTHPLACE (State or foreign country)

MD.

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

CHARLES WHITMORE

14. MOTHER'S MAIDEN NAME

NANNATH

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

HUSBAND, George W. Lange - same

18. 162X I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A)

CARCINOMA of BRAIN
(METASTASES)

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

CARCINOMA of LUNG

DUE TO

(C)

INTERVAL BETWEEN
ONSET AND DEATH

?

?

II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

12/1/50

19B. MAJOR FINDINGS OF OPERATION

METASTATIC CARCINOMA

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH21B. PLACE OF INJURY (e.g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11/25, 1950, to 12/6, 1950, that I last saw the
deceased alive on 12/6, 1950, and that death occurred at 2P m., from the causes and on the date stated above.

23A. SIGNATURE

John F. Strahan

M. D.

23B. ADDRESS

University Hosp.

23C. DATE SIGNED

12/6/50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

12/9/50

24C. NAME OF CEMETERY OR CREMATORY

Moreland Park

24D. LOCATION (City, town, or county)

Balt Md

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

William Williams

25. FUNERAL DIRECTOR

ADDRESS

J. Buck 5305 Harford Rd

DEC 7 - 1950

VS 150

471

SM-1-00

J. J. Ruch

30
10-10483

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50-10483

BIRTH NO. 50-26464

1. NAME OF DECEASED (Type or Print) <i>Baby (Boy) Gossett</i>			2. DATE OF DEATH <i>12-6-50</i>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>13-06</i>		
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>Mercy Hospital</i>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore City - 11</i>		
c. Length of stay in Baltimore <i>14 hr 12 min</i>			D. STREET ADDRESS (If rural, give location) <i>3302 Keswick Rd</i>		
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Single</i>	8. DATE OF BIRTH <i>12-5-50</i>	9. AGE (In years last birthday)	10. Under 1 Year Months: Days
10A. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <i>Newborn</i>			11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		
12. CITIZEN OF WHAT COUNTRY?			13. FATHER'S NAME <i>Vance Gossett</i>		
14. MOTHER'S MAIDEN NAME <i>Charlotte Anderson</i>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <i>No</i>		
16. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS <i>Mother</i>		

18. *7600* I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

CAUSE OF DEATH
(A) *Ex Uterine Subdural, Subarachnoid and Intra-ventricular Hemorrhage*
(B) *Atelelectases of Lungs (Prolonged difficult labor)*
(C)

INTERVAL BETWEEN ONSET AND DEATH

14 hours

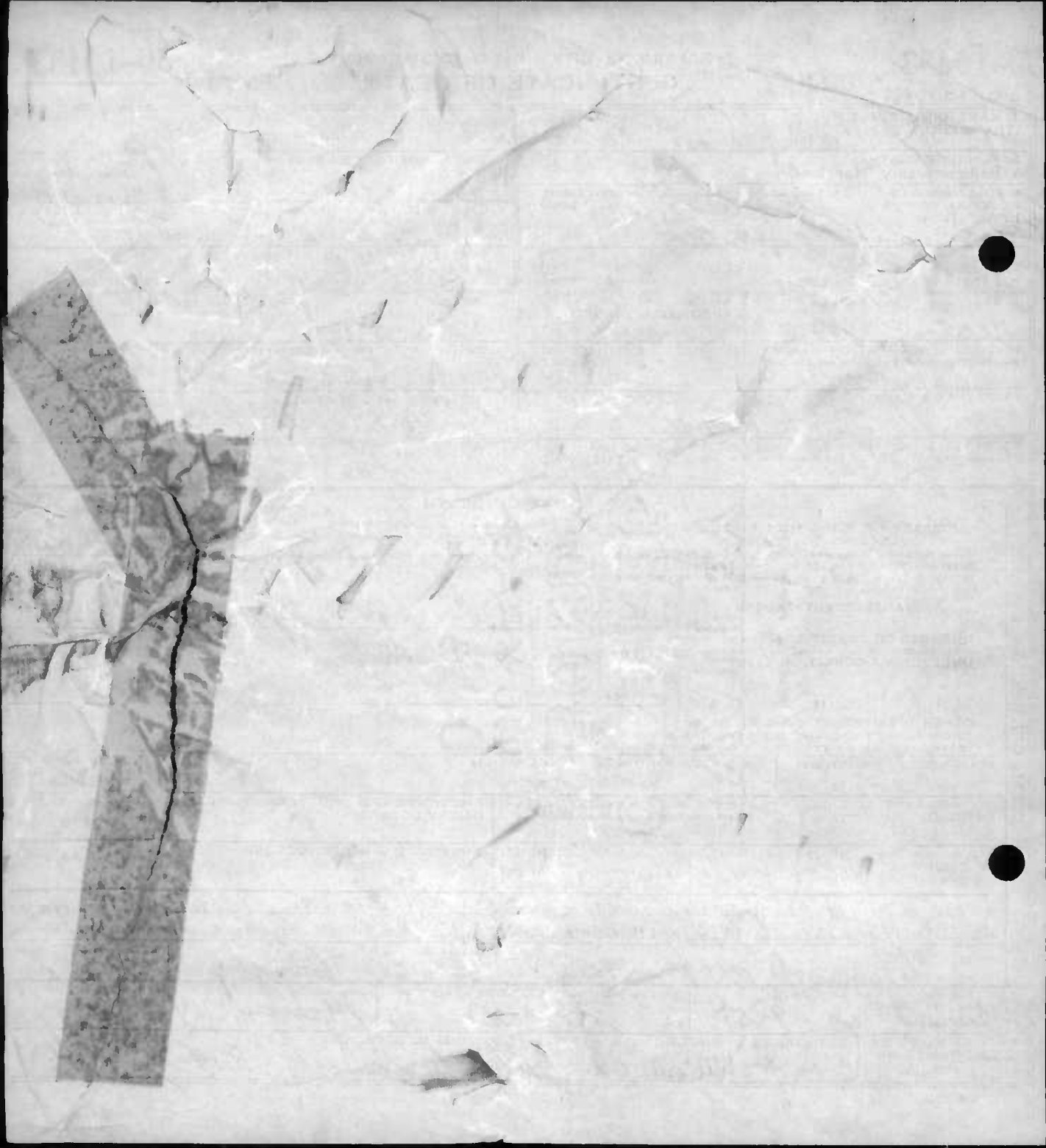
MEDICAL CERTIFICATION

19A. DATE OF OPERATION <i>None</i>		19B. MAJOR FINDINGS OF OPERATION <i>None</i>		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from *Dec 5* 19*50* to *Dec 6*, 19*50* that I last saw the deceased alive on *Dec 6*, 19*50*, and that death occurred at *7:46* A.m., from the causes and on the date stated above.

23A. SIGNATURE <i>Leonard J. Humberg M.D.</i>	23B. ADDRESS <i>Mercy Hospital</i>	23C. DATE SIGNED <i>12-6-50</i>
---	------------------------------------	---------------------------------

24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>12-9-50</i>	24C. NAME OF CEMETERY OR CREMATORY <i>Marion Va.</i>	24D. LOCATION (City, town, or county) (State)
DATE RECEIVED BY LOCAL REGISTRAR <i>DEC 7 - 1950</i>	REGISTRAR'S SIGNATURE <i>William H. Williams</i>	25. FUNERAL DIRECTOR <i>Frank H. Sarty</i>	ADDRESS <i>814 236th St.</i>



BALTIMORE CITY HEALTH DEPARTMENT

50-10484

CERTIFICATE OF DEATH

Registered No.

BIRTH NO. 50-10484 60-26465

1. NAME OF DECEASED
(Type or Print)

Baby Girl Gossett

2. DATE
OF
DEATH

12-6-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF
HOSPITAL OR
INSTITUTION (If not in hospital or institution, give street address or location)

Mercy Hospital

c. Length of stay in Baltimore

11 hrs 50 min

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

12-5-50 6:38 am

9. AGE (In years,
last birthday)

11 Under 1 Year

Months: Days

11 58

10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Newborn

10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Vance Gossett

14. MOTHER'S MAIDEN NAME

Charlotte Anderson

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(If yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

Mother

ADDRESS

(above)

18. 760.0 I

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

CAUSE OF DEATH

① Subdural Hemorrhage

(A)

DUE TO

② Ateke tissues of all but
Left upper lobe of lung
(Difficult Labor)

(B)

DUE TO

(C)

INTERVAL BETWEEN
ONSET AND DEATH

12 hours

19A. DATE OF OPERATION

None

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐
WORK WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec 5, 1950, to Dec 6, 1950 that I last saw the
deceased alive on Dec 6, 1950, and that death occurred at 5:32 a. m., from the causes and on the date stated above.

23A. SIGNATURE

Leonard G. Anderson

M. D.

23B. ADDRESS

Mercy Hospital

23C. DATE SIGNED

12-6-50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

12-9-50

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town or county) (State)

Marion Va.

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

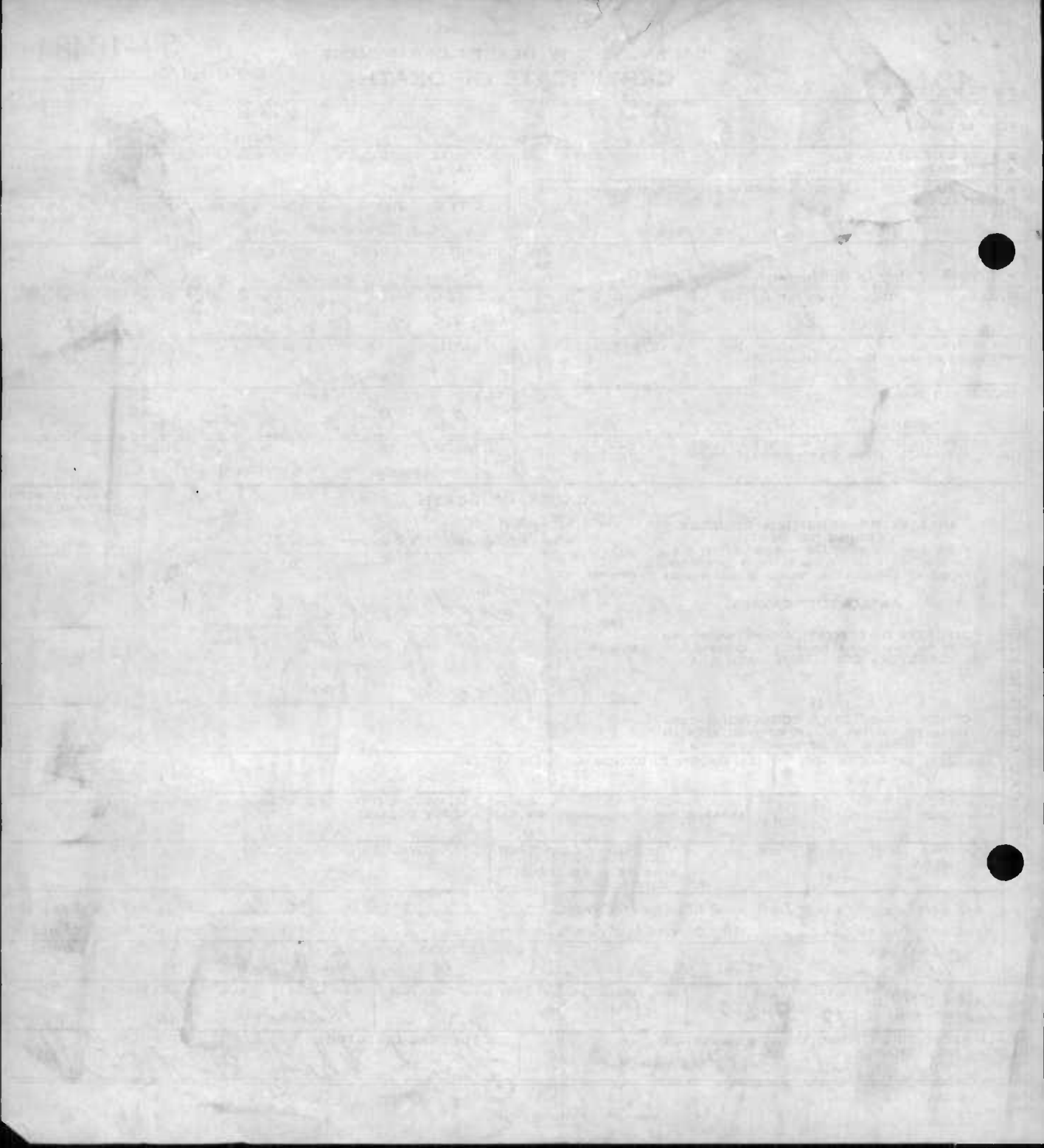
DEC 7 - 1950

Wm. J. Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

Frank J. Sarty 814 2436th St



**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

Registered No. **50-10485**

50-10485

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

BRADEN R. FREY

2. DATE
OF
DEATH

December 7, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION

Union Memorial Hospital

C. Length of stay in Baltimore

Yrs.
Mos.
Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

140 N. Culver Street

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

MARRIED

8. DATE OF BIRTH

Nov. 23, 1919

9. AGE (In years
last birthday)

31

10. Under 1 Year
Months: Days

11. Under 24 Hours
Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

ROUTEMAN

10B. KIND OF BUSINESS OR INDUSTRY

BAKERY

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

HARRY FREY

14. MOTHER'S MAIDEN NAME

JULIA ECKART

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

YES

World War II

16. SOCIAL
SECURITY NO.

216-10-8712

17. INFORMANT

ADDRESS

ANGELA FREY 140 N. CULVER ST.

18. **E919.6**

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) **Pulmonary embolus**

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

Gunshot wound of chest

INTERVAL BETWEEN
ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. EXTERNAL CAUSE WAS
UNDERLYING ☒ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)

Grocery store

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

618 Arlington Avenue

21D. TIME (Month) (Day) (Year) (Hour)

Nov. 22, 1950 10:00 A.m.

21E. INJURY OCCURRED

WHILE AT ☒ WORK NOT WHILE ☐ AT WORK

21F. HOW DID INJURY OCCUR?

Firearms

22. I certify that I took charge of the remains described above, held an **Autopsy** thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☒.

23A. SIGNATURE

William J. Smith

23B. CHIEF MEDICAL EXAMINER.....☐

ASSISTANT MEDICAL EXAMINER.....☒

M.D. MEDICAL INVESTIGATOR.....☐

23C. DATE SIGNED

Dec. 7, 1950

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

BURIAL

24B. DATE

12-11-50

24C. NAME OF CEMETERY OR CREMATORY

BALTIMORE NATIONAL

24D. LOCATION (City, town, or county)

BALTIMORE, Md.

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

DEC 7 - 1950

William J. Smith

George L. Schwab 2101 Frederick Ave.

N-8624-6326A

184

MEDICAL CERTIFICATION



512
10-10486BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50-10486
Registered No.

1. NAME OF DECEASED (Type or Print) JOHN THOMPkins			2. DATE OF DEATH December 7, 1950		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE District of Columbia		
B. FULL NAME OF HOSPITAL OR INSTITUTION Baltimore City Hospital			C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township) Washington		
C. Length of stay in Baltimore			D. STREET ADDRESS (If rural, give location) 133 T Street, N. W.		
5. SEX Male	6. COLOR OR RACE Colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH 1918	9. AGE (In years last birthday) 32	10. Under 1 Year Months Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer			11. BIRTHPLACE (State or foreign country) Pennsylvania		
10B. KIND OF BUSINESS OR INDUSTRY Construction work			12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME John J. Thompson, Sr.			14. MOTHER'S MAIDEN NAME Beatrice Giles		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
17. INFORMANT Catherine Thompson			ADDRESS 133 T St. N.W.		

18. E902.5 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) Basilar skull fracture DUE TO ANTECEDENT CAUSES (B) Extradural, subdural, subarachnoid hemorrhage (C) Laceration of right frontal lobe INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) Street	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 1500 Block S. Clinton Street, Canton
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY December 6, 1950 11:00A.	21E. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR? Fell to ground from a scaffold
22. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input checked="" type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .		
23A. SIGNATURE William V. [Signature]	23B. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> MEDICAL INVESTIGATOR <input type="checkbox"/>	23C. DATE SIGNED Dec. 7, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial	24B. DATE Dec. 7, 1950	24C. NAME OF CEMETERY OR CREMATORY Washington, D.C.	24D. LOCATION (City, town, or county) (State) Washington, D.C.
DATE RECEIVED BY LOCAL REGISTRAR DEC 8 - 1950	REGISTRAR'S SIGNATURE [Signature]	25. FUNERAL DIRECTOR Mr. Kate R. Williams Schroeder	
VS 151	97024	186a	

33-1-5

CHINESE

635

50-10487

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10487

Registered No.

BIRTH NO. 50-24909

1. NAME OF DECEASED
(Type or Print)

Jessica Ann Gardner

2. DATE
OF
DEATH

12-7-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or
HOSPITAL OR location)
INSTITUTIONBaltimore City Hospitals
4940 Eastern Ave.4. USUAL RESIDENCE (Where deceased lived, If institution: residence
A. STATE before admission)

Md.

B. COUNTY:

Baltimore

C. CITY OR TOWN (If outside corporate limits, write RURAL and give
township)

Baltimore

Middle River

D. STREET ADDRESS (If rural, give location)

1609 Wilson Pt. Rd.- 20

5300

c. Length of stay in Baltimore

Life

Yrs.
Mos.
Days

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Single

10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR
INDUSTRY

8. DATE OF BIRTH

Nov. 20, 1950

9. AGE (In years
last birthday)If Under 1 Year
Months Days

17

If Under 24 Hours
Hours Min.

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

James Gardner

14. MOTHER'S MAIDEN NAME

Ellen Martin

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

B. C. H. Records, 4940 Eastern Ave.

18. 061X

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A) Tetanus

DUE TO

9 days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

Dec. 1, 1950

19B. MAJOR FINDINGS OF OPERATION

Tetanus

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

m. WHILE AT ☐ NOT WHILE
WORK AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11-30-1950 to Dec. 7, 1950, that I last saw the
deceased alive on Dec. 7, 1950, and that death occurred at 3:15 PM from the causes and on the date stated above.

23A. SIGNATURE

J. S. Rogers M. D.

23B. ADDRESS

4940 Eastern Ave.

23C. DATE SIGNED

Dec. 7, 1950

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

12-8-50

24C. NAME OF CEMETERY OR CREMATORY

Lained Heart of Penn

24D. LOCATION (City, town, or county)

Baltimore Md.

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

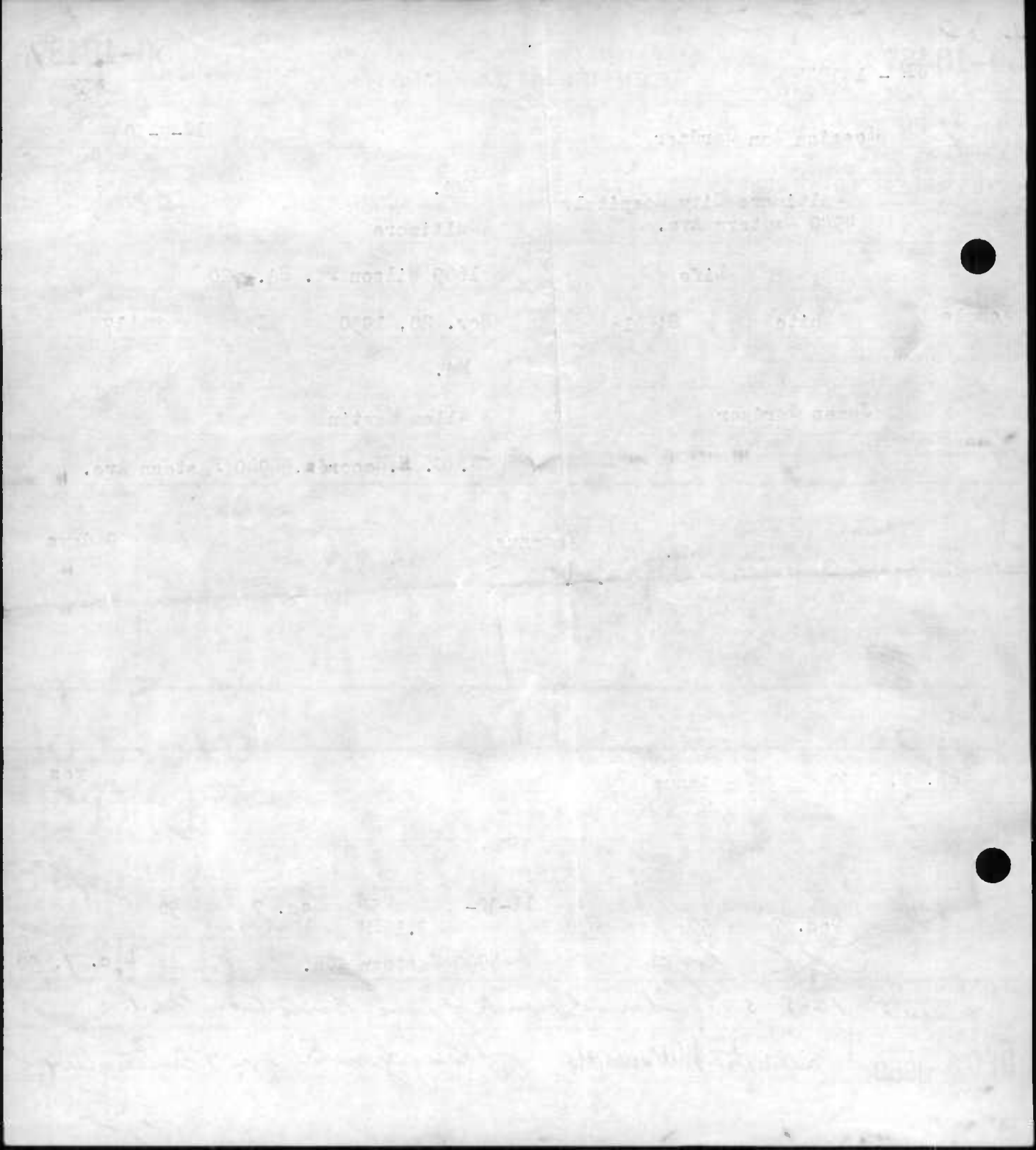
Walter Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

J. Brydgenahi 1407 Eastern Ave

DEC 8 - 1950



300
50-10488

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10488

Registered No. _____

1. NAME OF DECEASED (Type or Print) WILLIE MAE LLOYD			2. DATE OF DEATH 12-7-50		
3. PLACE OF DEATH: A. Baltimore City, Maryland 1030 W. Saratoga			4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE Maryland B. COUNTY _____		
B. FULL NAME OF HOSPITAL OR INSTITUTION 1030 W. Saratoga St			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore		
c. Length of stay in Baltimore 23			D. STREET ADDRESS (If rural, give location) 1030 W. Saratoga		
5. SEX Female	6. COLOR OR RACE Colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 9-29-'06	9. AGE (In years last birthday) 44	H Under 1 Year Months: Days: H Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10B. KIND OF BUSINESS OR INDUSTRY Same		11. BIRTHPLACE (State or foreign country) Lawrence Co. S.C.	
13. FATHER'S NAME William Hughes			14. MOTHER'S MAIDEN NAME Clara Rice		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no		16. SOCIAL SECURITY NO.		17. INFORMANT Engelstalland	
				ADDRESS 1028 W. Saratoga St	
18. 442X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Cerebral hemorrhage DUE TO Cardiovascular renal disease DUE TO INTERVAL BETWEEN ONSET AND DEATH 38 hrs					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION none		19B. MAJOR FINDINGS OF OPERATION			
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 12-5- 19 50 , to 12-7- 19 50 , that I last saw the deceased alive on 12-7- 19 50 , and that death occurred at 1:45p.m. , from the causes and on the date stated above.					
23A. SIGNATURE John E. J. Pumper		M. D. 639 N. Carey St		23C. DATE SIGNED 12-7-50	
24A. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 12/11/50		24C. NAME OF CEMETERY OR CREMATORY MT. CALVARY	
24D. LOCATION (City, town, or county) A.A. Co. MARYLAND		25. FUNERAL DIRECTOR Wm. A. Jackson - 916 PENNA. AVE.			

MEDICAL CERTIFICATION

DATE RECEIVED BY LOCAL REGISTRAR
DEC 8 - 1950

REGISTRAR'S SIGNATURE
Wm. A. Jackson

02101-01

VALLEY
CONGRESS
EDWARD
100% F/C

200
50-10489

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10489
Registered No.

1. NAME OF DECEASED (Type or Print) LEO J. LEWIS			2. DATE OF DEATH November 23, 1950		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Virginia B. COUNTY V-43		
B. FULL NAME OF (If not in hospital or institution, give street address or location) Johns Hopkins Hospital			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Norfolk		
C. Length of stay in Baltimore Yrs. Mos. Days			D. STREET ADDRESS (If rural, give location)		
5. SEX male	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) U	8. DATE OF BIRTH U	9. AGE (In years last birthday) 62	10 Under 1 Year Months: Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY K	11. BIRTHPLACE (State or foreign country) K		12. CITIZEN OF WHAT COUNTRY
13. FATHER'S NAME N		14. MOTHER'S MAIDEN NAME N			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. N	17. INFORMANT W ADDRESS N		

18. 491X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Antecedent Causes DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		CAUSE OF DEATH (A) Bronchopneumonia DUE TO (B) DUE TO (C) OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		INTERVAL BETWEEN ONSET AND DEATH
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19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		

22. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐.

23A. SIGNATURE <i>Stanley K. Dunbar</i> M.D.		23B. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> MEDICAL INVESTIGATOR <input type="checkbox"/>	23C. DATE SIGNED Nov. 24, 1950
24A. BURIAL, CREMATION, REMOVAL (Specify) DEC 8 - 1950	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY UNIVERSITY MEDICAL SCHOOL	24D. LOCATION (City, town, or county) (State) DEC 7 - 1950

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE <i>Christina M. Williams</i>	25. FUNERAL DIRECTOR Commissioner of Health	ADDRESS
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BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

CERTIFICATE OF DEATH

350
50-10480
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10480
Registered No.

1. NAME OF DECEASED (Type or Print) FRANK			2. DATE OF DEATH November 12, 1950		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Mryland B. COUNTY		
B. FULL NAME OF HOSPITAL OR INSTITUTION Maryland General Hospital			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore		
C. Length of stay in Baltimore			D. STREET ADDRESS (If rural, give location) 1605 Eutaw Place		
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) U	8. DATE OF BIRTH U	9. AGE (In years last birthday) 48	If Under 1 Year Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY K	11. BIRTHPLACE (State or foreign country) K		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME O			14. MOTHER'S MAIDEN NAME O		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO. N	17. INFORMANT N ADDRESS		

18. 581.0 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Chronic pyelonephritis with terminal uremia DUE TO Uremic pericarditis Early cirrhosis of liver Fatty infiltration of liver	INTERVAL BETWEEN ONSET AND DEATH
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21F. HOW DID INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE AT WORK <input type="checkbox"/>				

22. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE <i>William V. Smith</i>		23B. CHIEF MEDICAL EXAMINER..... ASSISTANT MEDICAL EXAMINER..... M.D. MEDICAL INVESTIGATOR.....		23C. DATE SIGNED 11-13-50	
24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY UNIVERSITY MEDICAL SCHOOL		24D. LOCATION (City, town, or county) (State) DEC 7 - 1950	

DATE RECEIVED BY LOCAL REGISTRAR DEC 8 - 1950	REGISTRAR'S SIGNATURE <i>William V. Smith</i>	25. FUNERAL DIRECTOR Commissioner of Health	ADDRESS
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BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age		4. Date of death	
5. Place of death		6. Cause of death		7. Manner of death		8. Signature of physician	
9. Signature of registrar		10. Signature of coroner		11. Signature of medical examiner		12. Signature of funeral director	
13. Signature of undertaker		14. Signature of cemetery		15. Signature of burial place		16. Signature of interment	
17. Signature of burial place		18. Signature of interment		19. Signature of burial place		20. Signature of interment	
21. Signature of burial place		22. Signature of interment		23. Signature of burial place		24. Signature of interment	
25. Signature of burial place		26. Signature of interment		27. Signature of burial place		28. Signature of interment	
29. Signature of burial place		30. Signature of interment		31. Signature of burial place		32. Signature of interment	
33. Signature of burial place		34. Signature of interment		35. Signature of burial place		36. Signature of interment	
37. Signature of burial place		38. Signature of interment		39. Signature of burial place		40. Signature of interment	
41. Signature of burial place		42. Signature of interment		43. Signature of burial place		44. Signature of interment	
45. Signature of burial place		46. Signature of interment		47. Signature of burial place		48. Signature of interment	
49. Signature of burial place		50. Signature of interment		51. Signature of burial place		52. Signature of interment	
53. Signature of burial place		54. Signature of interment		55. Signature of burial place		56. Signature of interment	
57. Signature of burial place		58. Signature of interment		59. Signature of burial place		60. Signature of interment	
61. Signature of burial place		62. Signature of interment		63. Signature of burial place		64. Signature of interment	
65. Signature of burial place		66. Signature of interment		67. Signature of burial place		68. Signature of interment	
69. Signature of burial place		70. Signature of interment		71. Signature of burial place		72. Signature of interment	
73. Signature of burial place		74. Signature of interment		75. Signature of burial place		76. Signature of interment	
77. Signature of burial place		78. Signature of interment		79. Signature of burial place		80. Signature of interment	
81. Signature of burial place		82. Signature of interment		83. Signature of burial place		84. Signature of interment	
85. Signature of burial place		86. Signature of interment		87. Signature of burial place		88. Signature of interment	
89. Signature of burial place		90. Signature of interment		91. Signature of burial place		92. Signature of interment	
93. Signature of burial place		94. Signature of interment		95. Signature of burial place		96. Signature of interment	
97. Signature of burial place		98. Signature of interment		99. Signature of burial place		100. Signature of interment	

400
10-10491BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10491

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Mary Agnes Gill

2. DATE
OF
DEATH

Dec. 7, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF
HOSPITAL OR
INSTITUTION (If not in hospital or institution, give street address or location)
2634 Edmondson Ave.

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
BaltimoreD. STREET ADDRESS (If rural, give location)
2634 Edmondson Ave.

c. Length of stay in Baltimore

Life

Yrs.
Mos.
Days

5. SEX

F

6. COLOR OR RACE

W

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

W

10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Home

10B. KIND OF BUSINESS OR
INDUSTRY

Home

13. FATHER'S NAME

Patrick Gleason

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

No

16. SOCIAL
SECURITY NO.
No

17. INFORMANT

ADDRESS

Mrs. Mary McCarthy 2634 Edmondson

18. 1538

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A)

Carcinoma of Colon

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE, (A) STATING THE
UNDERLYING CONDITION LAST.

DUE TO

(C)

Ch. tubercular heart disease

1945

INTERVAL BETWEEN
ONSET AND DEATH

6 mos.

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 10, 1950 to Dec 7, 1950, that I last saw the
deceased alive on Dec. 7, 1950, and that death occurred at 7:13 A.M., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

M. D.

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

Burial

12/9/50

St. Mary's

Baltimore, Md.

DATE RECEIVED BY
LOCAL REGISTRAR

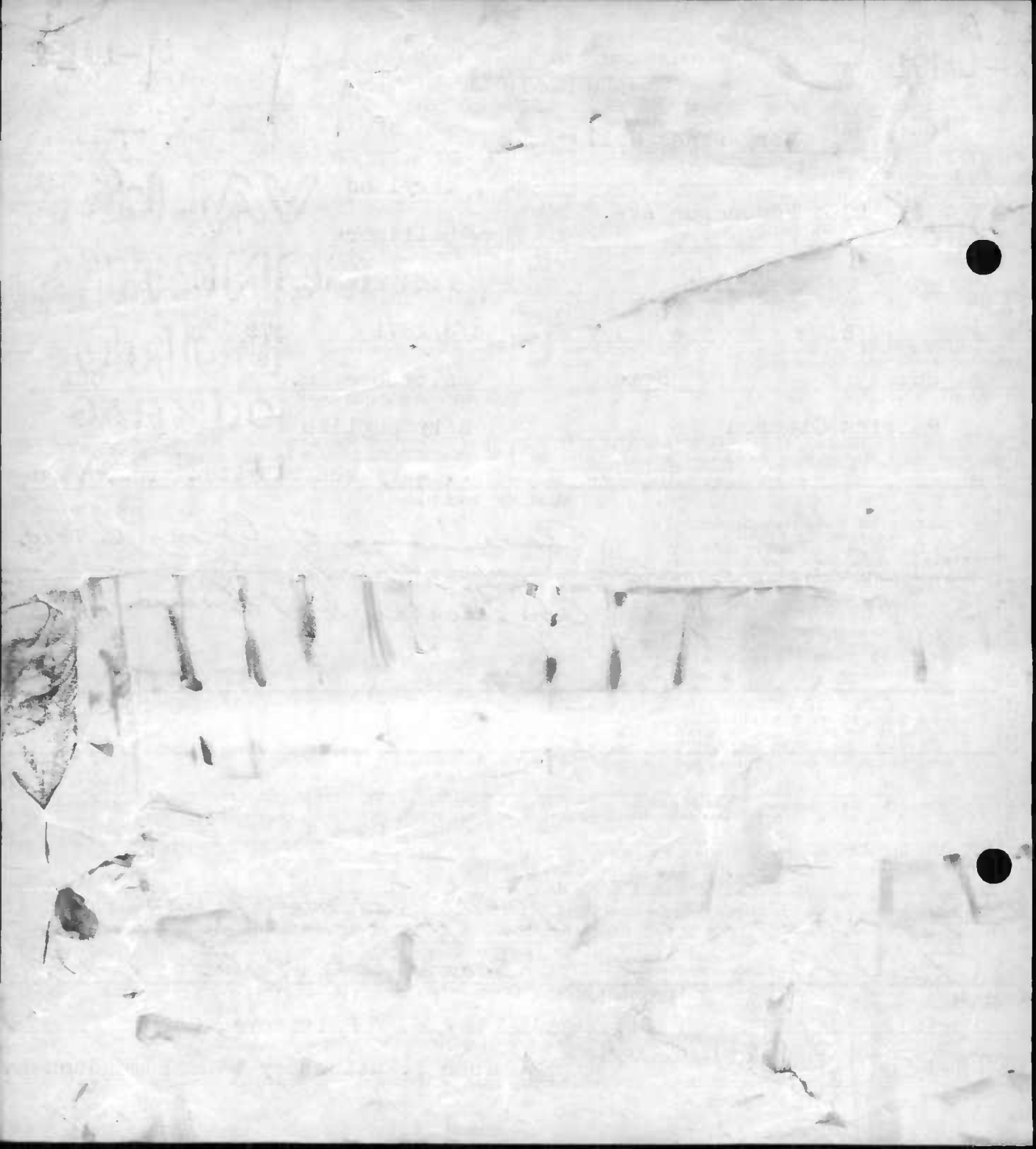
REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

DEC 8 - 1950

John T. Stansbury 2700 Edmondson Av



25

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No.

50-10492

50-10492

BIRTH NO.

1. NAME OF DECEASED (Type or Print) HARRY ATKIN			2. DATE OF DEATH 12-6-50		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE BALTIMORE B. COUNTY Baltimore		
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION SINAI HOSPITAL			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore Overlea		
c. Length of stay in Baltimore life			D. STREET ADDRESS (If rural, give location) 706 HESLEY AVE - OVERLEA, 6 MD		
5. SEX M	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) SINGLE	8. DATE OF BIRTH 9-21-02	9. AGE (In years, last birthday) 48 (48)	10. Under 1 Year Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10B. KIND OF BUSINESS OR INDUSTRY Mens furnishings	11. BIRTHPLACE (State or foreign country) ENGLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Thomas Atkin			14. MOTHER'S MAIDEN NAME E. A. Rogers		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. 215-03-5746	17. INFORMANT ADDRESS F. C. Jones 2506 Frederick Ave.		

18. **582X** CAUSE OF DEATH INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) **Congestive HEART FAILURE** 15 hours

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) **LIVER ABSCESS**
DUE TO **CHRONIC PERITONITIS**

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION **12-1-50** 19B. MAJOR FINDINGS OF OPERATION **ABSCESS RIGHT LOBE OF LIVER** 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **11-21-50**, 19**50**, to **12-1-50**, 19**50**, that I last saw the deceased alive on **12-10-50**, and that death occurred at **7:10 P.M.**, from the causes and on the date stated above.

23A. SIGNATURE **Erwin A. Gohm** M. D. 23B. ADDRESS **Swan Hospital, Baltimore Md** 23C. DATE SIGNED **12-7-50**

24A. BURIAL, CREMATION, REMOVAL (Specify) **Burial** 24B. DATE **12/11/50** 24C. NAME OF CEMETERY OR CREMATORY **Parthwood** 24D. LOCATION (City, town, or county) (State) **Balto. Md.**

DATE RECEIVED BY LOCAL REGISTRAR **DEC 8 - 1950** REGISTRAR'S SIGNATURE **William A. Williams, M.D.** 25. FUNERAL DIRECTOR **Larsen Funeral Home** ADDRESS **4401 Belair Rd.**

CERTIFICATE OF DEATH

1910

1

1910

1910

500
50-10493

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10493
Registered No.

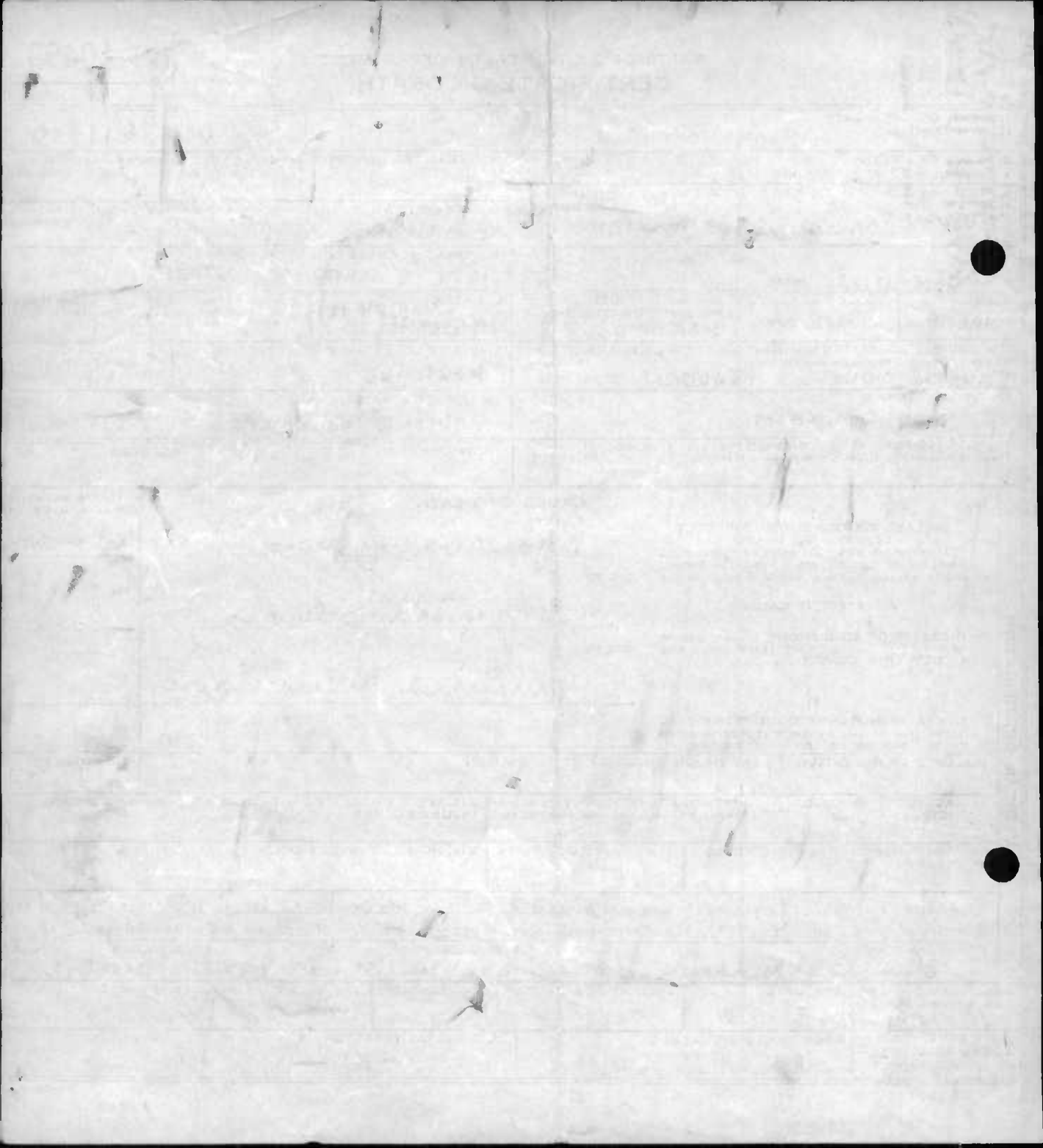
1. NAME OF DECEASED (Type or Print) JULIUS KEIM			2. DATE OF DEATH Dec. 6, 1950.		
3. PLACE OF DEATH: A. Baltimore City, Maryland <i>Balto. Md</i>			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <i>Md</i> B. COUNTY		
B. FULL NAME OF HOSPITAL OR INSTITUTION FRANKLIN SQUARE HOSPITAL			C. CITY OR TOWN (If outside corporate limits, give LOCAL and give township) BALTIMORE <i>23-02</i>		
c. Length of stay in Baltimore			D. STREET ADDRESS (If rural, give location) 1021 S. CHARLES STREET		
5. SEX MALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH MARYLAND JUNE 24, 1893		9. AGE (In years last birthday) 57
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TAVERN OWNER		10B. KIND OF BUSINESS OR INDUSTRY TAVERN	11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA.
13. FATHER'S NAME GEORGE KEIM			14. MOTHER'S MAIDEN NAME PAULINE RICKARTS		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	

18. <i>420.1</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	CAUSE OF DEATH (A) <i>myocardial fibrosis</i> DUE TO (B) <i>coronary arteriosclerosis</i> DUE TO (C) <i>generalized arteriosclerosis</i>	INTERVAL BETWEEN ONSET AND DEATH <i>Not known</i>
---	---	--

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>Oct 5</i> , 1950 to <i>Dec 6</i> , 1950, that I last saw the deceased alive on <i>Dec 6</i> , 1950, and that death occurred at <i>10:35</i> AM., from the causes and on the date stated above.					
23A. SIGNATURE <i>John W. Quinn</i>		23B. ADDRESS <i>M.D. Franklin Square Hosp.</i>		23C. DATE SIGNED <i>Dec 6, 1950</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	24B. DATE <i>12/9/50</i>	24C. NAME OF CEMETERY OR CREMATORY <i>HOLY CROSS</i>	24D. LOCATION (City, town, or county) (State) <i>PITCHEE HIGHLAND</i>		
DATE RECEIVED BY LOCAL REGISTRAR <i>DEC 8 - 1950</i>		REGISTRAR'S SIGNATURE <i>John W. Quinn</i>		25. FUNERAL DIRECTOR ADDRESS <i>JOHN F. DENNY, INC. 715 LIGHT ST-30</i>	

2906M

93D



656
50-10494
BIRTH NO.

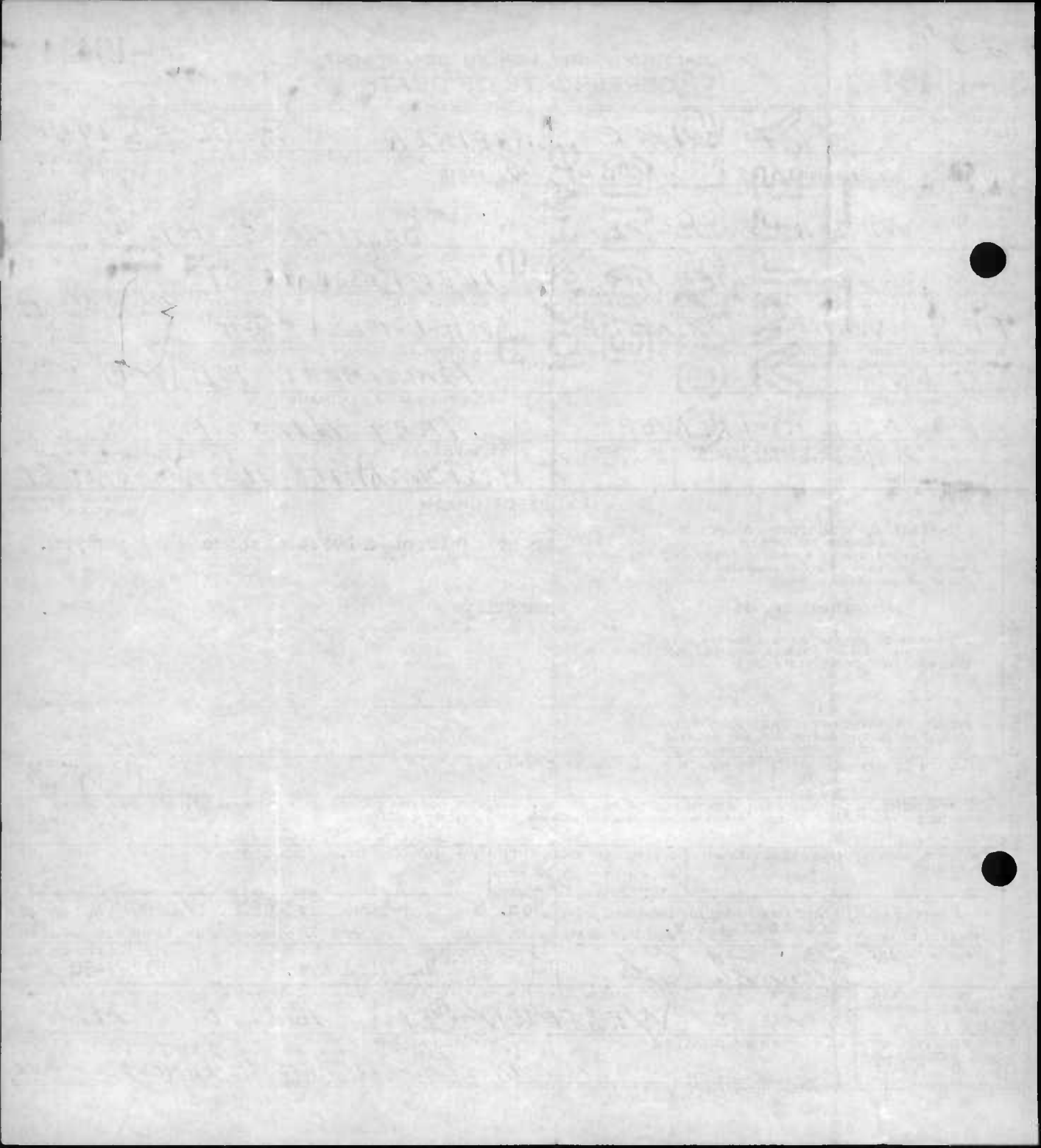
BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10494
Registered No.

1. NAME OF DECEASED (Type or Print) ELIZABETH C SCHREINER			2. DATE OF DEATH DEC-6-1950		
3. PLACE OF DEATH: A. Baltimore City, Maryland 3025 WINDSOR AVE			4. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) B. COUNTY 16-07		
5. FULL NAME OF HOSPITAL OR INSTITUTION WINSOR Conv. HOME			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE MD		
6. Length of stay in Baltimore LIFE TIME			D. STREET ADDRESS (If rural, give location) 1631 ROSEDALE ST		
5. SEX FEM	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) SINGLE	8. DATE OF BIRTH APRIL-6-1863	9. AGE (In years, last birthday) 87	If Under 1 Year Months: Days Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10B. KIND OF BUSINESS OR INDUSTRY -	11. BIRTHPLACE (State or foreign country) BALTIMORE MD		12. CITIZEN OF WHAT COUNTRY? U S
13. FATHER'S NAME JACOB SCHREINER			14. MOTHER'S MAIDEN NAME MARY HIRSCH		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS MRS EDNA RITTER-1631 ROSEDALE ST		

18. 4200	CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(A) arteriosclerotic heart disease	sev yrs.
DUE TO		(B) senility	
DUE TO		(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			

19A. DATE OF OPERATION 0		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Dec. 6 , 19 50 to 1:30 PM , 19 50 , that I last saw the deceased alive on not seen alive , 19 50 , and that death occurred at m. , from the causes and on the date stated above.					
23A. SIGNATURE E. Elsworth Cook		23B. ADDRESS 2431 Maryland Ave.		23C. DATE SIGNED 12-7-50	
24A. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24B. DATE DEC-9-50		24C. NAME OF CEMETERY OR CREMATORY WESTERN CEM	
24D. LOCATION (City, town, or county) BALTO		24E. STATE MD		25. FUNERAL DIRECTOR Mrs Chas A G Rohde	
DATE RECEIVED BY LOCAL REGISTRAR DEC 8-1950		REGISTRAR'S SIGNATURE William H. Williams, M.D.		25. FUNERAL DIRECTOR ADDRESS 2327 SUMMONSON AVE	



520

0-10495

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10495

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

ERNEST FERDINAND LANG

2. DATE
OF
DEATH

Dec. 6, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)

3617 Wabash Avenue

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Md.

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3617 Wabash Avenue

c. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

male

6. COLOR OR RACE

white

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

married

8. DATE OF BIRTH

June 10, 1873

9. AGE (In years
last birthday)

77

10. Under 1 Year
Months: Days11. Under 24 Hours
Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Guard

10B. KIND OF BUSINESS OR INDUSTRY

Art Gallery

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

John Lang

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Emma Lang - 3617 Wabash Ave.

18. 4221 I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(A) Subarachnoid Hemorrhage
DUE TO Arteriosclerotic Cardio-
Vascular Disease
(B)
DUE TO
(C)

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH21B. PLACE OF INJURY (e.g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov 1st, 1950, to Dec 6, 1950, that I last saw the deceased alive on Dec 6, 1950, and that death occurred at 6 P m., from the causes and on the date stated above.

23A. SIGNATURE

Albert Scagnetti

M. D.

23B. ADDRESS

1729 W. Lombard St

23C. DATE SIGNED

Dec 7 50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

12/9/50

24C. NAME OF CEMETERY OR CREMATORY

Loudon Park Cem.

24D. LOCATION (City, town, or county)

Balto., Md.

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

DEC 8 - 1950

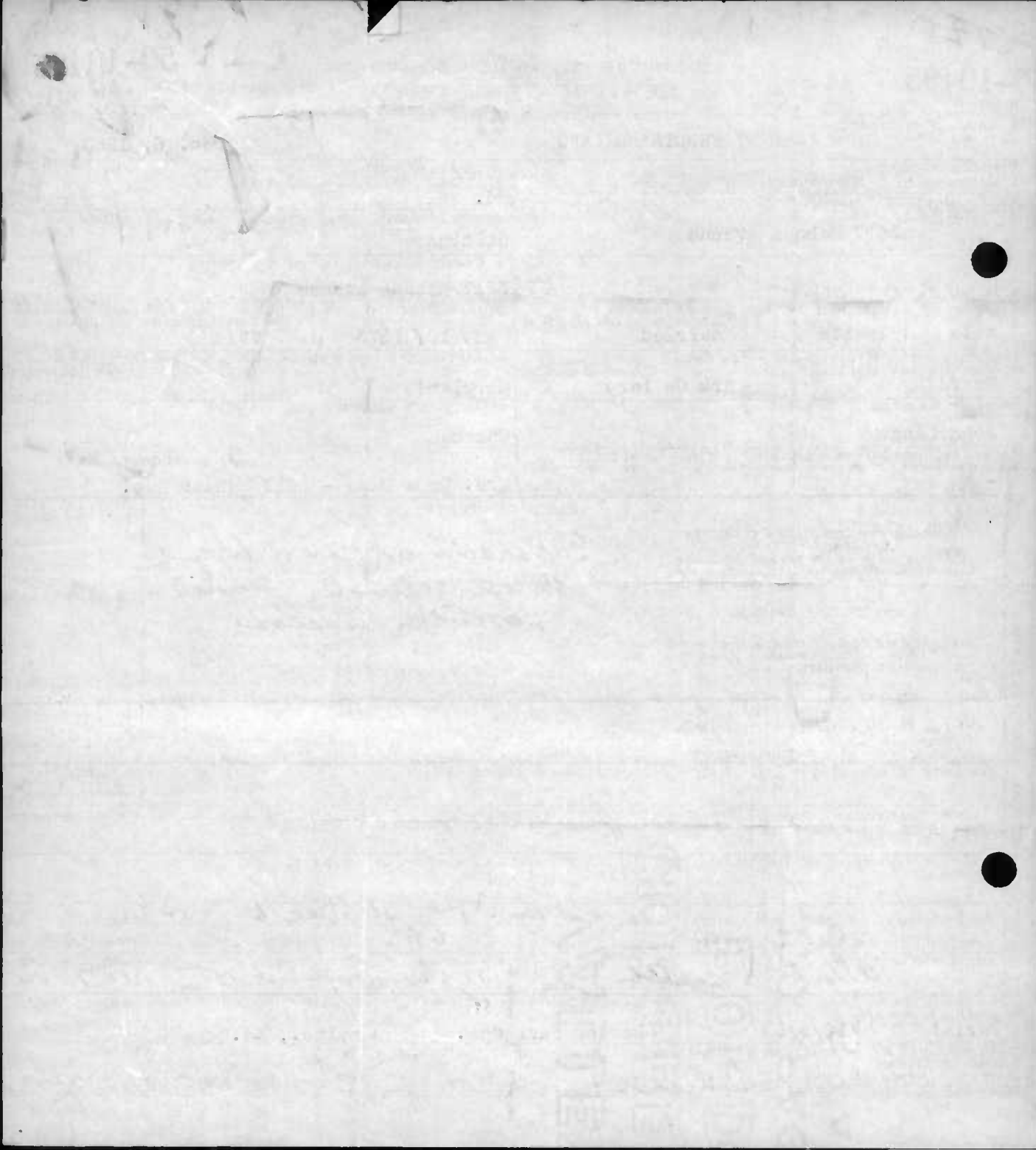
VS 150

25. FUNERAL DIRECTOR

ADDRESS

Hm. J. Fickner & Sons - Balto
937 Md.

MEDICAL CERTIFICATION



260

CERTIFICATE CORRECTED 12-14-50

50-10496

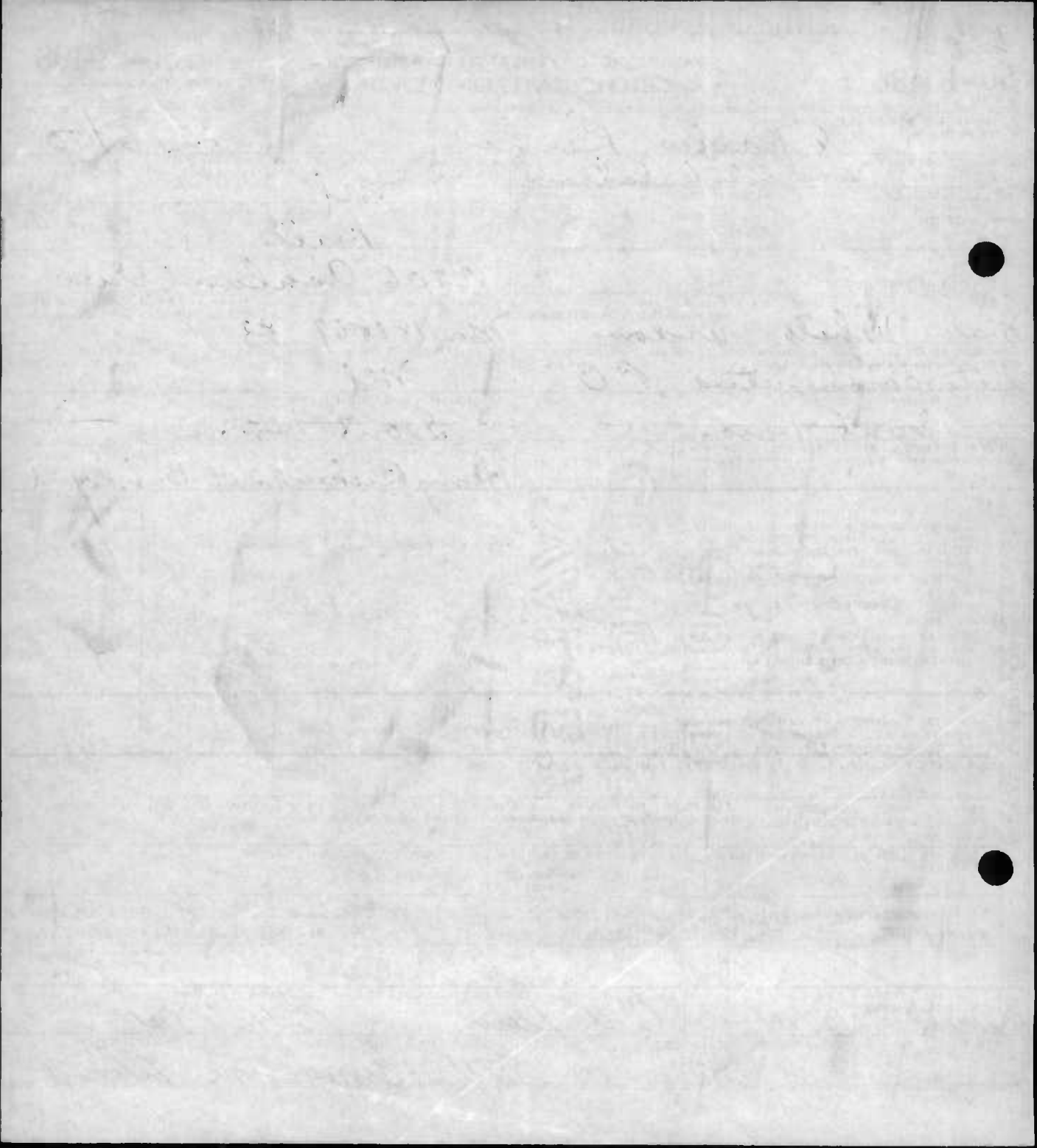
BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10496

Registered No.

1. NAME OF DECEASED (Type or Print) <i>Charles Becker</i>		2. DATE OF DEATH <i>12/6/50</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <i>2206 Ashland</i>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MD</i> B. COUNTY <i>7-03</i>	
B. FULL NAME OF HOSPITAL OR INSTITUTION		C. CITY OR TOWN (If outside corporate limits, write FULLY, and give township) <i>Balti</i>	
C. Length of stay in Baltimore <i>Life</i>		D. STREET ADDRESS (If rural, give location) <i>2206 Ashland Ave</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>widow</i>	8. DATE OF BIRTH <i>1868</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>letter carrier retired</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>PO</i>	9. AGE (in years last birthday) <i>82</i>
11. BIRTHPLACE (State or foreign country) <i>MD</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Don't Know</i>		14. MOTHER'S MAIDEN NAME <i>Don't Know</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>no</i>		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Henry Becker 2206 Ashland</i>		ADDRESS	
18. <i>420.0</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) <i>acute myocardial insufficiency</i> DUE TO (B) <i>arterio-sclerotic heart disease</i> DUE TO (C) <i>general arterio-sclerotic atherosclerosis</i> INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i>		19. DATE OF OPERATION	
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH	
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I hereby certify that I attended the deceased from <i>Dec. 4</i> , 19 <i>50</i> , to <i>Dec. 6</i> , 19 <i>50</i> , that I last saw the deceased alive on <i>Dec. 6</i> , 19 <i>50</i> , and that death occurred at <i>3:00 P.</i> m., from the causes and on the date stated above.	
23A. SIGNATURE <i>L. C. Dobihal</i>		23B. ADDRESS <i>4474 Kenwood Ave.</i>	
23C. DATE SIGNED <i>Dec 8, 1950</i>		24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	
24B. DATE <i>12/10/50</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Cath Lawn</i>	
24D. LOCATION (City, town, or county) (State) <i>Calgary MD</i>		25. FUNERAL DIRECTOR <i>Wilhelm Funeral Home</i>	
DATE RECEIVED BY LOCAL REGISTRAR <i>DEC 8 - 1950</i>		REGISTRAR'S SIGNATURE <i>William H. Williams, M.D.</i>	
VS 150		93D	

MEDICAL CERTIFICATION



**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

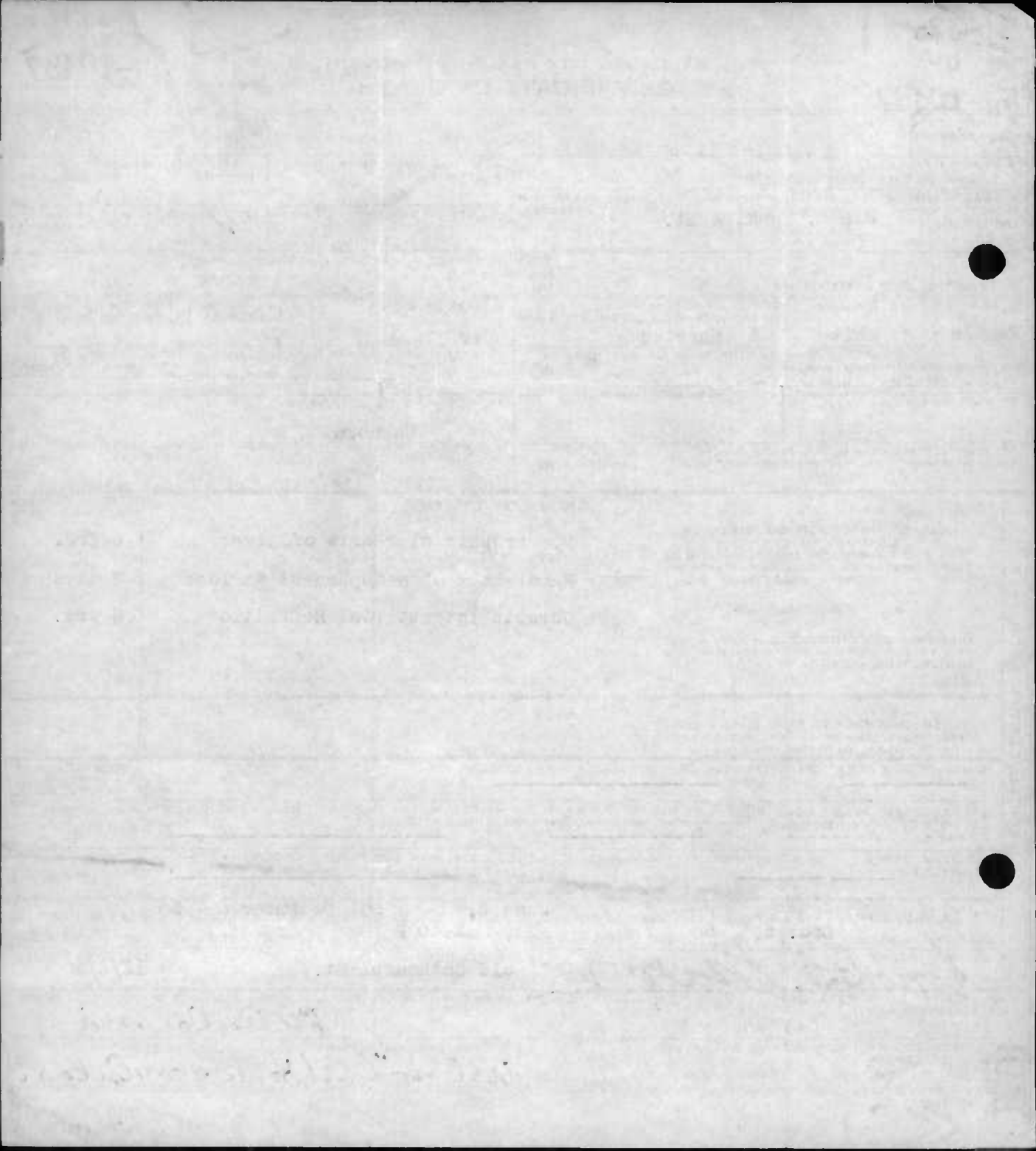
Registered No. **50-10497**

BIRTH NO. 50-10497

1. NAME OF DECEASED (Type or Print) Fannie Wittig			2. DATE OF DEATH Dec 5 1950		
3. PLACE OF DEATH: A. Baltimore City, Maryland 326 S Newkirk			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md B. COUNTY Baltimore C. CITY OR TOWN 26-07 D. STREET ADDRESS (If rural, give location) 326 S Newkirk		
B. FULL NAME OF HOSPITAL OR INSTITUTION 326 S. Newkirk St.			8. DATE OF BIRTH Dec - 3, 1890		
c. Length of stay in Baltimore Yrs. 0 Mos. 0 Days 0			9. AGE (In years last birthday) 60 If Under 1 Year Months: Days: If Under 24 Hours Hours: Min.		
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	11. BIRTHPLACE (State or foreign country) Germany		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			12. CITIZEN OF WHAT COUNTRY? Germany		
10B. KIND OF BUSINESS OR INDUSTRY at home			14. MOTHER'S MAIDEN NAME Unknown		
13. FATHER'S NAME Wimmer			17. INFORMANT ADDRESS John Wittig 154 Elizabeth Ave Landsdowne		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Wimmer			16. SOCIAL SECURITY NO. Unknown		

18. 581.0 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Hypertrophic Cirrhosis of Liver		INTERVAL BETWEEN ONSET AND DEATH 6 Yrs.
(A) DUE TO Hemorrhage of oesophageal varices		2 days
(B) Chronic Interstitial Nephritis		2 yrs.
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION 0		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from June 8, 1950 to December 5, 1950 , that I last saw the deceased alive on Dec. 5, 1950 and that death occurred at 2:40 P.m. , from the causes and on the date stated above.					
23A. SIGNATURE Amelia J. Brown		23B. ADDRESS 516 Cathedral St.		23C. DATE SIGNED 12/6/50	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE Dec 8/50		24C. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore Md		25. FUNERAL DIRECTOR ADDRESS William H. Williams, Jr. 2004 Orleans			



352
50-10498BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50-10498

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Florence Marie Nothnagel

2. DATE
OF
DEATH

December 7, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION 1131 Brentwood Avenue4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
BaltimoreD. STREET ADDRESS (If rural, give location)
1131 Brentwood Avenue

c. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

female

6. COLOR OR RACE

white

7. SINGLE, MARRIED,
WIDOWER, DIVORCED (Specify)

married

8. DATE OF BIRTH

June 1, 1898

9. AGE (In years
last birthday)

52

If Under 1 Year
Months: Days
If Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

housewife

10B. KIND OF BUSINESS OR
INDUSTRY

own home

11. BIRTHPLACE (State or foreign country)
New York City, N. Y.12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Frederick Medenbach

14. MOTHER'S MAIDEN NAME
Maria Miller15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.17. INFORMANT ADDRESS
Wm. Nothnagel, 1131 Brentwood Avenue

18. 422.1

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)(A) Chronic Myocarditis (diffuse)
DUE TO

?

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) arteriosclerosis
DUE TO
(C)

?

II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER-
LYING OR CONTRIBUTING
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE
WORK AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1 April, 1950, to 7 Dec., 1950, that I last saw the
deceased alive on 6 Dec., 1950, and that death occurred at 4 A. M., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

burial

24B. DATE

12/9/50

24C. NAME OF CEMETERY OR CREMATORY

St. Matthews Cemetery

24D. LOCATION (City, town, or county)

Baltimore,

(State)

Maryland

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

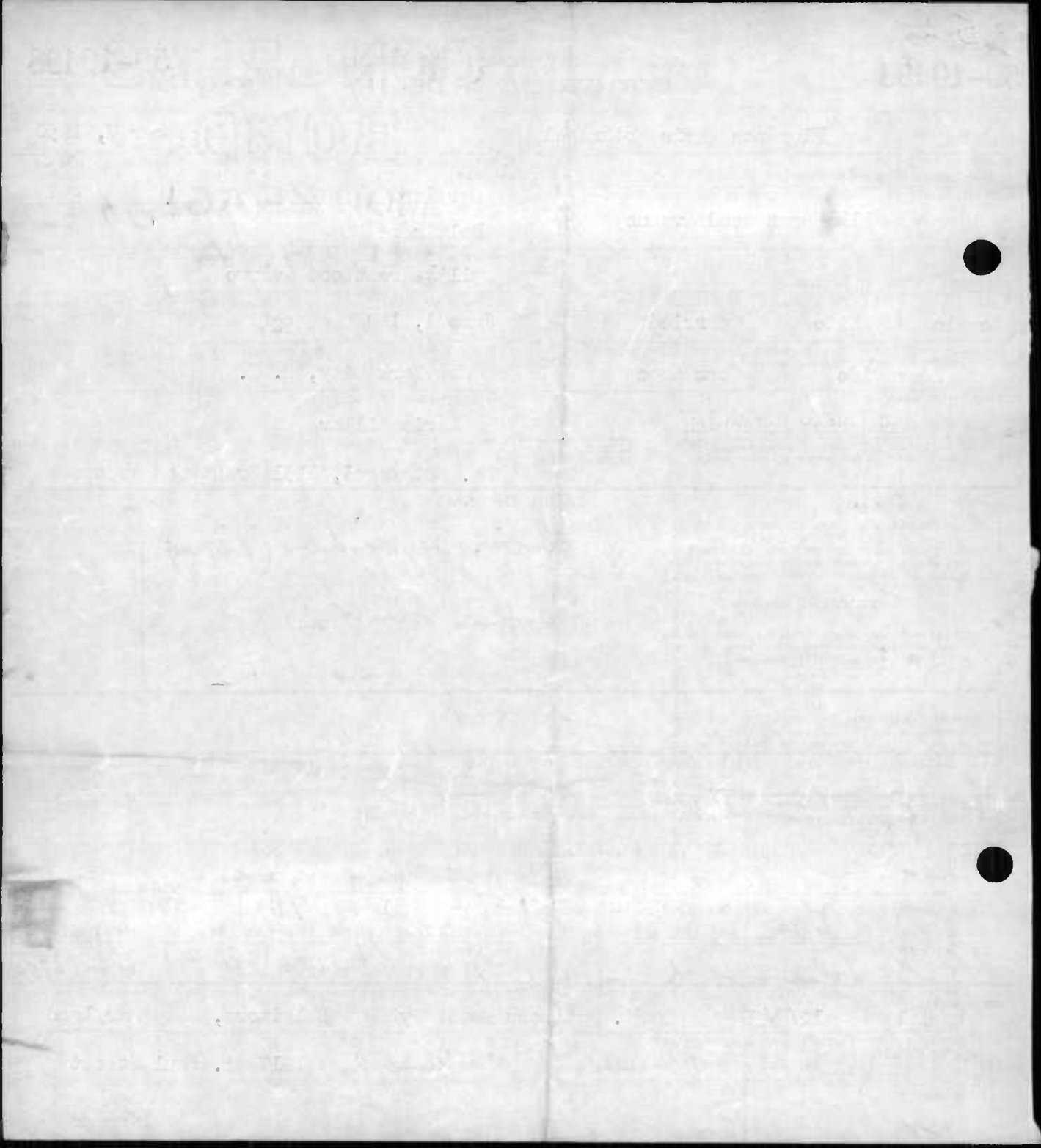
ADDRESS

DEC 8 - 1950

Huntington Williams, M.D.

Wm. Cook, Inc.

1217 St. Paul Street



656

10499

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10499

Registered No.

1. NAME OF DECEASED (Type or Print) MARY J. TURNER			2. DATE OF DEATH 12.6.50		
3. PLACE OF DEATH: A. Baltimore City, Maryland BALTIMORE			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY		
B. FULL NAME OF HOSPITAL OR INSTITUTION DOCTORS HOSPITAL			C. CITY OR TOWN (If outside corporate limits, write R.O.A.S. and give township) BALTIMORE. 16-08		
c. Length of stay in Baltimore life			D. STREET ADDRESS (If rural, give location) 3703 WOODRIDGE RD. 29.		
5. SEX F	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) MARRIED.	8. DATE OF BIRTH Sept. 12, 1892		9. AGE (In years last birthday) 58 y3.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife			10B. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) Baltimore, Md.
13. FATHER'S NAME Philip Hoffman			14. MOTHER'S MAIDEN NAME Katherine M. Heilman		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no			16. SOCIAL SECURITY NO. no		
17. INFORMANT Wade H. Turner, husband, above			ADDRESS		
18. 151X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Alcohol, Pneumonia & Epyemia DUE TO			INTERVAL BETWEEN ONSET AND DEATH 2 wks.		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Ca of Stomach DUE TO			6 wks.		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION Nov. 7. 50.		19B. MAJOR FINDINGS OF OPERATION Carcinoma of Stomach (Partial Gastrectomy)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Nov. 26, 1950 , to DEC. 6, 1950 , that I last saw the deceased alive on DEC. 6, 1950 , and that death occurred at 1:30 pm. , from the causes and on the date stated above.					
23A. SIGNATURE Richard J. Swartzfeld		23B. ADDRESS 5402 Belair Rd.		23C. DATE SIGNED 12-6-50.	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE Dec. 9, 1950		24C. NAME OF CEMETERY OR CREMATORY Meadowridge Mem. Park	
24D. LOCATION (City, town, or county) Washington Blvd.,		24E. LOCATION (State) Washington			
DATE RECEIVED BY LOCAL REGISTRAR DEC 8 - 1950		REGISTRAR'S SIGNATURE William Williams		25. FUNERAL DIRECTOR Schimunek Funeral Home, Inc.	
				ADDRESS 2601-3-5 E. Madison St.	

8410

UNITED STATES DEPARTMENT OF THE ARMY
OFFICE OF THE CHIEF OF MEDICAL SERVICE
WASHINGTON, D. C. 20315

WCO

WCO

WCO

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WCO

WCO

WCO

625

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50-10500

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Edna Regester Harrison

2. DATE
OF
DEATH

12/7/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)
A. STATE B. COUNTY

Maryland

8. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

Edgewood Nursing Home

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

Length of stay in Baltimore

60

Yrs.
Mos.
Days

D. STREET ADDRESS (If rural, give location)

Homewood Apts., Charles & 31st Sts.

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)
Married

8. DATE OF BIRTH

9. AGE (In years last birthday)

60

If Under 1 Year Months: Days
If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

None

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Edward Church Regester

14. MOTHER'S MAIDEN NAME

Hattie Wilcox

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Lloyd Harrison Homewood Apartments

18.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A)

Cirrhosis of liver

1 yr.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from Aug 19, 1950, to Dec 7, 1950, that I last saw the deceased alive on Dec 6, 1950, and that death occurred at 3A m., from the causes and on the date stated above.

23A. SIGNATURE

Roman R. Freeman R. M. D.

23B. ADDRESS

11 W. 29th St.

23C. DATE SIGNED

Dec 8, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

12/9/50

24C. NAME OF CEMETERY OR CREMATORY

Lorraine Cemetery

24D. LOCATION (City, town, or county)

Woodlawn, Md.

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

DEC 8 - 1950

16. W. Mealy and Son 805 N. Calvert St.

VS 150

124 R

MEDICAL CERTIFICATION

Please write the cause of death in the space provided.

